Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day4 Feb. ŽÕ10 Gertrude Hoffman Cohen 7:27 Рм Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Rockville Shady Grove Adventist Hospital Montgomery Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign **Funeral** Months Days Hours Min. Sep Month, Day, Year) 908 **Director** 101 Poland 095-30-8464 Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20850 U.S.A. 8 Baltimore Road Apt 407 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces?
1 ☐ Yes 2 ※ No Black White, etc. þ 1 Never Married 2 Married 72 hours after Maryland 21215-0036 White 1 ☐ Yes 2X No Specify: ould be filed within 72 hours aft of Mental Hygiene. marked other than "natural", If Yes Give Completed 3 ₩ Widowed 4 □ Divorced Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Samuel Joseph Hoffman Esther Hoffman and 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Selma C. Kunitz/Daughter Health tem 27 <u>6406 Tilden Lane, Rockville, Maryland 20852</u> Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of IImportant: If ite
any injury or ot cemetery, crematory or other place) 1 Removal from State King David Mem. Grds. 2/21/2010 |Falls Church, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address ward Sagel Funeral Direction, Inc Signature of Funeral Service Licensee Melissa C Greenhut MC Greenha 1091 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 2 Owe erk Beath Immediate Cause (Final Pneumonia Ph sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner 2 Years Chronic Pleural Effusion Sequentially list conditions if any, leading to immediate cause. Enter Unidenying Cause (Disease or iinjury Due to (or as a consequence of) Exami Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Box 68760 the F attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year ed by the a Unknown 9 Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, Old Age 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 : autopsy performed? Yes 2 No 1 Yes 2 X No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 😾 No ပ္ 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes Certificate: 28d. Describe how injury occurred injury 5 Pending 1 🔀 Natural 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) Medical 29a, Certifier 25 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Dav. Year)

State Registrar ama

Shama R.

Mittal, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D0061382

9901 Medical Center Drive, Rockville, Maryland 20850

February 15, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State o	f Marylan		artment of I tificate of I		nd Mental H	/	10	06502
			Registrar 1. Decedent's Name (First, Middle,	Last)		061	incate of L	Jean	2. Date of D		, ,	3. Time of Death
	Physicia Medic		ALBERT	CHAL	-OM				Month Feb	wary 12,	^{Year} 2010	2:03 am
	Examin		4a. Facility Name (if not institution,		-		4b. City, Town, o			4c. County	of Death	
	Francis		Future Care Nu 5. Social Security Number		7. Age (In yrs. la	ast hirthday)	If Under 1 Year	altimo.		Rinth	() Diethol	and /State or English
	Funeral Director		039-28-4838	1 X M 2 □ F	7.6		Months Days		Min. 10/08/		Counti	ace (State or Foreign ⁹⁾ Egypt
	t ow		Usual Residence of Decedent 10a, State 10b, County									
	arylan a-f sh iled a	Director			10c. Cit	y, Town or Lo		ltimor	0		od. Inside City Limits	
	he Ma or 28a notif	Dire	Maryland 10e. Street and Number				10f. Zip Code	MIIIO/L	.e	10g. Citizen of \	Vhat Count	
	with t	Funeral	6200 Eas.	tern Aven	ue			21224		u.s.A.		
	within 72 hours after death with the Maryland giene. gret than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at		11. Marital Status	Armed For	dent Ever in U.S		Vas Decedent of H f Yes, specify Cuba	lispanic Origini an, Mexican, P		e - America		
36	after Il", or xamii	d by	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☑ Divorced	ed 1 🗆 Yes If Yes, Give	2 🔀 No e		☐ Yes 2 🌠 No		, , , , , , , , , , , , , , , , , , , ,	Specify:	k, White, e	
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Maryland	be filed within 72 hours after death with the Maryland ental Hygiene. *Ked other than "natural", or items 23a or 28a-f show ic event, the Medical Examiner must be notified at	10 E	17. Father's Name (First, Middle, La	c Chalom				18. Mother's	Name (First, Middl Sanh i	e, Maiden Surname Le Mandal	•	
a _Z	2 should buth and Mer th and Mer 77 is mark traumatic		19a. Informant's Name/Relationship			19b. Mailin	g Address (Street	and Number o	or Rural Route Numi			ode)
	id 2 st salth a n 27 is er tra		Sol Chalom -	Brother			-					and 20902
_	ge 1 and 3 nt of Healt If item 2 or other		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3	Removal from		Place of Dispo	sition (Name of natory or other place	ce)	Date	20c. Location ~	City or Tov	vn, State
E H	and		4 Donation 5 Other (Sp	ecify)	Mt.				2/14/2010			
Rai	permit. Departr Imports any inju		21. Signature of Funeral Service Lic	ensee //	18/39							Home, Inc. 1. MD 20904
			23a. Part 1. Enter the disease, or c shock, or heart failure. List on	omplications that c ly one cause on eac	aused the deatl ch line.	h, Do not ente	r the mode of dyin	g, such as car	diac or respiratory	arrest,		Approximate Interval Between
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and.	Examiner			Due to (or as a consequ	nce of):	W.					
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200	ending use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outo			Ectopic pregnanc	216		23d. Dat	e of deliver	y
X Pox	ueaur he attr ed for	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		nant at time of c		Other (specify)	- y		Мо	nth [Day Year
5	d by t		Part II. Other significant condition	s contributing to de	eath but not res	ulting in the u	nderlying cause giv	ven in Part I.	23e Did	tobacco use contr	ibute to the	cause of death?
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E S	rtificat	Φ	25. Was case referred to medical				26. Pl:	ace of Death	1 L Yes Check only one)	2 ⊉ No 1	☐ Yes 2	2 ∐ No
X	his ce	To B	examiner? 1 Yes 2 No		Inpatient 2 🗌		t 3 🗆 DOA Othe	er: 4 🗓 Nursi	ng Home 5 🗆 Res	sidence 6 Othe	r (Specify)	
UIVISION OT	To the hospital on Actending Priystodis. The law requires that the death certified within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending p completed filled in by the funeral director, page 2 should be detached for use as it.	Certificate:	27. Manner → Death 1 Natural 5 Pending 2 Accident Investiga		of injury h, Day, Year)	28b. Time of injury	28c. Injury work M 1 🗆			how injury occurre	ed	
NISIN	fer de irecto	ertif	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	28e. Place	of Injury - At ho ig, etc. (Specify,	me, farm, stre	et, factory, office			(Street and Number	r or Rural F	Route Number,
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100	hin 24 h the Fun	Medical	(Check 2 Medical Excords) Medical Excords and Certifying N	aminer: On the basi lurse Practioner: T	s of examination	and/or investi	igation, in my opinio	on, death occur	rred at the time, date	and place, and due	to the caus	e(s) and manner stated.
, F	ラック		29b. Signature and title of certifier	loja			29c. License	753	7	29d. Date signed	(Month, Da	ay, Year) 0
•			30. Name and address of person wh	odempleted cause	e of death (Item	23a) (Type, P	MOUNT	Poyal	Ave	Zaltin.	ne H	021217
	Stat Registra		31. Date filed (Month, Day, Year) FEB 18 2	010 33/Re	egistrar's Signat	. par	ris					ay, Year) 0 1) 2/2/7

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 06503 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February ^D6, 2010 Cabrera Augusto 12:50 a M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Friends Nursing Home Sandy Spring Montgomery Social Security Number 579-50-0209 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) ine 17, 1910 1 🛣 M 2 🗆 F Min. 99 Months Hours June Guatemala **Director** Usual Residence of Decedent show 10a. State 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f sho idical Examiner must be notified at Maryland Montgomery Silver Spring 1 🗆 Yes 2 🔀 No ۵ 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 15316 Pine Orchard Drive, #82-1B 20906 USA e filed within 72 hours after death wi ntal Hygiene. ed other than "natural", or items 2 event, the Medical Examiner mus 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? 1 Yes 2 No Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 K Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Chauffer Transportation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental H is marked ot Felipe Cabrera Maria DeJesus other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any Injury or other trau once. Mary Lily Waszkiewicz/Daughter 15420 Liberty Road, Mount Airy, MD 21771 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) Feb. 2010 ⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery 4 Donation 5 Other (Specify) Silver Spring, Maryland 21. Signatur of Funeral Service Licensee 22 Name and Address of Faculty Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Enter the disease, or c Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Coronary Artery Disease vear Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disperse) Examine Due to (or as a consequence of) attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical ves, outcome of pregnancy Live Birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) IF FEMALE 23b. Was decedent pregnant 23d, Date of delivery in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Month Day Year signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed Hypertension 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has autopsy performed? certificate 2 🗆 No 2 **3** N 1 Yes Yes To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 🗖 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 1 Tyes 2 🙀 No 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

State Registrar

completed

Box 68760

P.0.

Division of Vital Records,

31. Date filed (Month, Day, Year) FEB 18 2010 DHMH 17 Rev 7/2009

cal

29a. Certifier

29b. Signature

(Check

and title of cartifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Arthur Schoengold, MD 18111 Prince Philip Drive, Olney, MD 20832

2. Registrar's Signature

15 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number D18726

29d. Date signed (Month, Day, Year) February 12, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State Registrar	e of Maryland / Depa <i>Cer</i>	artment of Health : tificate of Death	and Mental Hy	/giene Reg. No. 2 A [0.0001					
	Di	- ,	Decedent's Name (First, Middle, Last)			2. Date of D	eath	3. Time of Death					
	Physicia Medic		ELVA CATHE		,	Month Febru	ary 14.2010	12.30 A ^M					
	Examin	er	4a. Facility Name (if not institution, give street and		4b. City, Town, or Location of								
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	nd how at	=	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Loc	cation			10d. Inside City Limits					
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212	withir		6	B (1-4 Of 5+)	maker		Own Home	e					
Maryland 21215-0036	ntal Hy ed ott	To Be	17. Father's Name (First, Middle, Last) Keefer Earl Adkins			r's Name <i>(First, Middle</i> :ie Emma Ro	· · · · · · · · · · · · · · · · · · ·						
aryli	ould b	ľ	19a. Informant's Name/Relationship (Type, Print)	10h Mailin	ng Address (Street and Number			Tip Code)					
ž	id 2 sh balth an n 27 is er trau		Patricia Moore / Daugh		Hessong Bridg			,					
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal fr	20b. Place of Dispo	sition (Name of natory or other place)	Teb. 20, 2010	20c. Location - City of	or Town, State					
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Ba	perm Depa Impo any i		21. Signature of Fun Servic Licensee	22 Ri	Name and Address of Facility esthaven Funer 501 Catoctin N	al Service Mountain Hw	s, Skkot Co v. Frederic	ody P.A.					
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В	g e g	hysic		regnant at time of death 5 L nknown	Other (specify)		Month	Day Teal					
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	1		30. Name and address of person who completed ca Sandeep Sharma, M.D.			.ck, MD 217	01						
	Stat	е		. Registrar's Signature									
	Registra			portion p.	SCORE COLOR								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Day Year in & 0 0 4c. County of Death /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner MI 10 Mursing 1-one onaconina 6 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9 Birthplace (State or Foreign Country) **Funeral** Date of Birth (Month, Day, Year) 1 M 2 ▼ F Months Days Hours Min Director 215-20-5242 88 Dec. 22,1921 Unknown Usual Residence of Decedent death with the Maryland 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ite Marilan Evan in the rust be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 No Allegany MD Rawlings 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21601 Granny Lane, S.W. Funeral 21557 IISA 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Armed Forces? 1 ∐Yes 2 👿 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 þ If Yes, Give Year or Dates 1 ☐Yes 2 XNo Specify. 3 Widowed 4 Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Laborer Textile Manufacturing 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) ဂ Michael Chucci Seraphina Poilucci 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peter Promutico/Nephew 21601 Granny Lane, S.W. Rawlings, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State Feb.27 4 ☐ Donation 5 ☐ Other (Specify) The Cumberland Crematory2010 Cumberland, MD 21. Signature of Funeral Service Licer 22. Name and Address of Facility Smith Funeral Home 85 S. Main Street Keyser, WV 26726 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ays disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be execute and Due to (or as a consequence of) burial-1 Box 68760. physician Physician/Medical attending ph IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 Cetopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 5 ☐ Other (specify) P.O. ned by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ dications 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No page 2 autopsy performed Yes 2 No certificate 1 □ Yes Physician: director. 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1∐Yes 2万No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred or Attending 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 🗆 No 24 hours after death filled in by the 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital Procedure 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the within 7 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

ORIGINAL

29c. License number

Road

DIC

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 02 Physician/ 1:20 A M Daugherto 2010 enne th Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Τοwη, or Location of Death 4c. County of Death **Examiner** Shock trauma Baltimore timore Cenk 5. Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Month, Day Year) 1 🕱 M 2 🗆 F Hours Min. Maryland Director 79 1930 213-26-4594 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 1 X Yes 2 No Maryland Harford Aberdeen 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 38 Greene Avenue 21001 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 X Married 1 Yes 2 X No Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: 3 - Widowed 4 - Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) laborer manufactoring 12 0 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Mary Elizabeth Johnson Clarence Earl Daugherty 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 38 Greene Ave., Aberdeen, MD 21001 William J. Daugherty (son) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Harford Memorial Gardens 3/3/10 Aberdeen, Maryland 21. Signature of Funeral Service Licenses Tarring-Cargo Funeral Home, P.A. Maryland 21001-3399 Aberdeen. 23a. Part 1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Intraceurial injulies including Sibduca longtoma disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to for as a consequence on APFROVED BY MEDICAL EXAMINER Syn Co PC Due to (or as a consequence of): that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit resulting in death) Last CERTIFICATION Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by bullation, coronary actor 1 Tes 2 No 3 Probably 4 X Unknown To the Hospital or Attending Physician: The law require within 24 hours after death.
To the Funeral Director: After this cartificate has been si completed filled in by the funeral director, page 2 should in Were autopsy findings available prior to completion of cause of With 24a. Was an autopsy death? 1 Yes 2 No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?

1 X Yes 2 No Hospital Other: 1 Nonpatient 2 ER/Outpatient 3 DOA ၉ 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28d. Describe how injury occurred Syncope Leading Certificate: 28b. Time of 28c. Injury at 1 . Natural 2 . Accident work? 1 ☐ Yes 2 🗶 No 5 Pending 1140PM Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 38 City or Town, State) ABES SEEN MD determined Home Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Murse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature a 29c. License number 29d. Date signed (Month, Day, Year) 27/2010 518272 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sommerkamp

Registrar DHMH 17 Rev 7/2009

State

24 South Exerc. Street

Baltimore

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 7:25 PM PHILIPPE DUVERGLAS **FEBRUARY** 14 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BETHESDA MONTGOMERY NATIONAL INSTITUTES OF HEALTH If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Min 1 XM 2 - F Director 051-74-4089 28 10/25/1981 NY Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at by Funeral Director 1 X Yes 2 No Bellerose Oueens 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe 23a 83-43 Commonwealth Blvd 11426 "natural", or items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 XNever Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: Afro-American 3 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Reynold Duverglas <u>Alexandra Hall</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u> Alexandra Duverglas/Mother</u> 83-43 Commonwealth Blvd. Bellerose, NY 11426 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1

■ Burial 2

□ Cremation 3

□ Removal from State 4 Donation 5 Other (Specify) 2/20/2010 Roslyn Cemetery Roslvn. NY Signature of Funeral Service Licenses 22. Name and Address of Facility Marshall's Funeral Home 4217 Ninth Street, NW Washington, DC 20011 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betwee Onset and Death Immediate Cause (Final Physician/ CONGESTIVE disease or condition resulting in death) Medical Due to (or as a consequence of) MEDIASTINAL B-CELL LYMPHOMA 18 **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Cause (Disease or linjury that initiated events resulting in death) Last physician and streets the burial-treets Due to (or as a consequence of): Certificate: To Be Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: ves, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 Fetal death in the past 12 months? Month Day Year Pregnant at time of death 1 Yes 2 g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 X No 3 ☐ Probably 4 ☐ Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 \(\text{No.} \) 25. Was case referred to medica 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 1 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this operated filled in by the funeral dil 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State, Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, lusie 2010 25HAOB421000 02 15 30. Name and address of person who completed cause a death (Item 23a) (Type, Print) BILUSIC MD. 10 CENTER DRIVE, BETHESDA 32. Registraris Signature State FEB 1 9 2010 Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mentai Hygiene

				,	Certificate of L	Death	Re	g. No 0	10 06509
	Dhysis	ion	Decedent's Name (First, Middle, Last)				2. Date of Death Month	3. Time of Death	
	, Physic /Medi		Norman Hoove	.~	Drayto	<u> </u>	2	T	010 6:40 AM
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	Funeral Director		231407345 10 M 2 F	. 1	Yrs. Months Days	Hours Min.	8. Date of Birth (Month, Dey,	1935	Country) V.A
	and and		10a. State 10b. County	10c. City, Towr	n or Location			··-	10d. Inside City Limits
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	h the	Funeral Director	10e. Street and Number		10f. Zip Code		10	g. Citizen of W	√hat Country?
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	e .	ne.	11. Marital Status 12. Was Decedent Armed Forces?		13. Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	pecify Yes or No- Rican, etc.)		e - American Indian, k, White, etc.
5-0020	permit. Pages 1 end 2 should be filled within 72 hours after death with the Maryland Depertment of Heatth end Mental Hygiene. Important: If Item 27 is marked other then "naturel", or itema 23e or 28e-f show eny injury or other treumatic event, the Medical Examiner must be notified at ance.		1 Never Married 2 Married 1 Yes 2 New Year or Detes:	ю		Specify:		Specify	Black
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d 2	Hygie Hygie ther t		17. Fether's Name (First, Middle, Last)		CITCE	18. Mother's Nam	ne (First, Middle, M		
an	ould be filed with Mental Hygiene. arked other than afto event, Iran	Be C	L. T. Drayton			Vaselii	_	arks	•
Maryiand	2 should I end Meni is marked	T _o	19a. Informant's Name/Reletionship (Type, Print)	19b	. Mailing Address (Street a	and Number or Ru	ral Route Number,	Cify or Town,	State, Zip Code)
	nd 2 sith e 27 Is	3	Roosevelt Drayton/Br	other 31	a 7th Stree	+ clark	suile, VI	A 230	127
Je,	es 1 end of Heaith I Item 27 r other tr	1	20a. Method of Disposition						
E	Pages nent of I int: If Ite		1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Chur	ch Cenet	eru :	2120/10C	larks	ville, VA
Baitimore,	permit. Pag Depertment Important: If eny Injury o		21. Signature of Funeral Service Licensee	/	Disposition (Name of yo, crematory or other place) 22. Name and Addres	s of Facility G	ceneF	: 14-	
Ω	82 5 8	- 1	Melsy & Threet						VA 22314
			23a. Part1. Enter the diseese, or complications that caused shock, or heart failure. List only one cause on each lin	the death. Do r	not enter the mode of dying	g, such as cardiac	or respiratory arre	st,	Approximate Interval Between
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		ner	resulting in death) a.	Due to (or as a	consequence of):				
	death certificate be executed e attending physicien end ed for use es the burlai-trensit	Examiner	Sequentially list conditions,	Due to (or as a	consequence of):				
60,	cien e		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	D	ent (a				
68760,	physic the t	edicai	that initiated events resulting in death) Last	Oue to (or as e c					
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Box	death cer attendir d for use	Physician/	Part II. Other significant conditions contributing to death but	et not reculting in	the underlying cause give	on in Part I	23h Did tot	acco use con	ntribute to the cause of death?
P.O.	the cathe	hys	Part II. Other significant conditions contributing to beautiful	t not resulting in	Title dilicertyllig cause give	en in realt i.		s 2 No	3 □ Probably 4 ☑ Unknown
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Records,	iew requires that the de as been signed by the a 2 shouid be detached	B					24a. Was an	autopsy ed?	24b. Were eutopsy findings available prior to
ec C	9 8 0	Completed							completion of cause of death?
E.	ysician: The is certificate he director, page	6					1 ☐ Yes	s 2 No	1 ☐ Yes 2 ☐ No
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of Vitai		P	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatie			4 AU Nursing H	ome 5 Resider		
	5 5 5	io io	27. Manner of Death 1 ☑ Natural 5 ☐ Pending (Month, Day) 2 ☐ Accident investigation		njury Work	(? Yes 2 □ No	200. Describe no	w injury occurr	60
Division	I or Attending after death. Director: Afte d in by the fune	ficat	3 Suicide 6 Could not be 28e. Place of Inju	ıry - At home, fa	rm, street, factory, office		28f. Location (Str.	eet and Numb	er or Rural Route Number,
S	or A safer	Certification:	4 Homicide determined building, etc.		,		City or Town,	State)	
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi	edicai C	29a. Certifier (Check only one) 11 Certifying Physician: To the best of 2 Medical Examiner: On the best of and manner sta	, and due to the ca rred at the time, da	use(s) and ma te and place, a	nner as stated. and due to the cause(s)			
_	Vithir To the	Me	29b. Signature and title of certifier		290 License	number	29	d. Date signe	d (Month Day, Year)
			K. Jan	ps.)OF5(040	\mathcal{A}	118/10
	16		30. Name and address of person who completed cause of de	ath (Item 23a) (٨	a #= (L	01	1 1120
	4		Dr. Khrorus Savachi	1801	Old Branch	~ Hoene	ee " To	4 U.	nten Mij 1010
1	Sta Regist		FEB 1 9 2010 Server 32. Registra	s Signature	led .				

Examiner Hospital or Attending Physician: The law requires that the death certificate be executed that but after death.

Fuheral Director: After this certificate has been signed by the attending physician and etely filled in by the funeral director, page 2 should be detached for use as the burlansit Division of Vital Records, P.O. Box 68760 n 24 hours the Funeral Dire

Pages 1 and 2 should be filed within 72 hours after death with the Marylan ment of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f shov ury or other traumatic event, the Medical Examinar must be notified at

Baltimore, Maryland 21215-0036

							performed? 1 □Yes 2 🔼 No	death? 1 □Yes 2 □No				
5. Was case referred to medical examiner?		26. Place of Death (Check only one)										
1 Yes 2 No	Hospit	tal: 1 ☐ Inpatient 2 ☐	Other (Specify)									
7. Manner of Death ↑★ Natural 5 Pending 2 Accident investig	g gation	Ba. Date of Injury (Month, Day, Year)	28b. Time of Injury	М	28c. Injury at Work? 1 ☐ Yes	2 🗆 No	28d. Describe how injury	occurred				
3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	not be ined 28	Be. Place of Injury - At he building, etc. (Specification)	lace of Injury - At home, farm, street, factory, office uilding, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)				
							e, and due to the cause(s) arred at the time, date and	and manner as stated. place, and due to the cause(s)				

29c. License number

158195

29d. Date signed (Month, Day, Year)

02/22/2010

3H5+1 State

To the within 2.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1138 Opal Ct Hogerstown, MD

31. Date filed (Month EB

29b. Signature and title of certifier

The MO

32. P gistrar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 Per FH G901 3/15/2010 JH State of Maryland / Department of Health and Mental Hygiene 2 1 1 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 20 2 SOLO 0736AM Medical 4a. Facility Name (if not institution, give street and number) 251 E Antiety 4b. City, Town, or Location of Death Examiner 4c. County of Death Hogerstown washir If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year, (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 ⋤ F Months Director 85 August Usual Residence of Decedent shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified 28a-f MD 1 Tyes 2 No Washington Hagerstown 5 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 23a Funeral 1942 Day Rd. 21742 U.S.A. items within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced "natural", or \$ Baltimore, Maryland 21215-0036 1 Tes 2 No Specify: Completed Specify: White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the Men Elementary/Seconday (0-12) College (1-4 or 5+) Aircraft Manufacturing Expediter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Samual D. Elliott Hazel Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edgar W. DeGraff / husband 1942 Day Road, Hagerstown, MD 21742 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ★ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Rest Haven Cemetery 2/25/2010 Hagerstown, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave., Hagerstown, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death ₽hysician/ reumonia disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner PSI 0 Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) аттепding physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death 1 Yes 2 D 9 Unknown detached Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an , page 2 s certificate has autopsy performed' 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?

1 \(\sum \) Yes 2 \(\sum \) No completed filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital ျှ 1 Finpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 Natural 2 Accident 5 Pending injury death. Investigation 1 Yes 2 🗌 No 24 hours after deat Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗌 within 2 To the I only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2012010 SILLTE CRIF 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hagerstam, MD 21740 31. Date filed (Month, Day, Year) State FEB 23 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Margaret Virginia Davis 16-2010 3:45A M 2 /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Salpburg pastal Hospice at the Lake WICOMICC If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Birthplace (State or Foreign Country) 1 M 2 X F Months Days Hours 218-24-5327 90 Director 11/26/1919 MD Usual Residence of Decedent 10a. State 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the "Modeal Extrainer must be notified an once. 28a-f show 10d. Inside City Limits Director 1 ☐ Yes 2 ☑ No MD Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21804 4027 Rural Place USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Margaret, LXVIS Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 □ Divorced Specify: white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Neil Smack Pearl Holston 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald Davis / son 8013 Shockley Rd., Snow Hill, MD 21863 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Powellville Cemetery 2/19/2010 Powellville, MD 22. Name and Address of Facility Burbage Funeral Home 21. Signalur of Funeral Service 108 William St., Berlin, MD 21811 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** MPZN) P2 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner DISURDEN SRIZURR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burlal-transit sician and burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12/penths?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 □Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred **J** □ Natural 5 ☐ Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 10052410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Huyam

31. Date filed (Month, Day, Year)

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 8 47 P 2. Date of Death Physician/ February 13 2010 Elmer N Delphey Jr Рм Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Frederick Frederick Memorial Hospital Frederick | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 9. Birthplace (St Months | Days | Hours | Min. | Min. | Nov. | 16, 1930 | Mary Land Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 9. Birthplace (State or Foreign 1 X M 2 □ F Months **Director** Yrs 220-26-0343 79 Usual Residence of Deceden 28a-f shov 10a, State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director Frederick Frederick Maryland 1 Yes 2 X No 10e Street and Number ŏ 10f. Zip Code 10g. Citizen of What Country? Examiner must be Funeral items 23a 6700 B. Overton Circle #13 21703 United States 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 X Yes 2 No 1948—
If Yes, Give
Year or Dates. 1952 1 Never Married 2 Married 3 Widowed 4 Divorced Black, White, etc. ō þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", Specify: Completed White the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b, Kind of Business Industry (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 8 Farmer Dairy Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H ည Elmer N. Delphey, Sr permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. Helen Boone 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Charlene Gunneaux / Daughter Gambrill Park Rd., Frederick, MD 21702 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Stauffer Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2/16/2010 Frederick, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Stauffer Funeral Home oustre 1621 Opossumtown Pike, Frederick, MD 21702 Part 1. Enter the disease, or complications the shock, or heart failure. List only one cause or se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Andon disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Gequentially list conditions, if any, leading to immediate cause. Enter Underlying Jer Due to (or as a consequence of): Examir or Attending Physician: The law requires that the death certificate be executed as the burial-transi Cause (Disease or iinjury and that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ō in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death Day be detached g 🖂 Ünknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy performed this certificate Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 1 No 1 \sum Yes Other: Certificate: To 1 Inpatient 2 MER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at neral Director: After filled in by the funer 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital within 24 hours To the Funeral Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 29b. Signature and title of certifie 22037

DHMH 17 Rev 7/2009

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

610

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Margaret E. Finn 1:00 A Feb 14 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Heart Homes at Piney Orchard Odenton Anne Arundel If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 220-14-5335 1 - M 2 - X (Month, Day, Year) Maryland Director 85 Jan. Usual Residence of Decedent 23a or 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at Director Anne Arundel Annapolis MD 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21409 1070 Broadview Drive USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces Black, White etc. Completed by 1 Never Married 2 Married 1 Yes 2 **X**No Baltimore, Maryland 21215-0036 White 1 Yes 2 X No Specify: 3 XWidowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) L.Greif & Brothers Office Worker 8 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Curly Hardesty Elsie Cumor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1070 Broadview Judith L. Barnes / Daughter Drive Annapolis, MD 21409 Date 19, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of I
Important: If ite
any injury or ot
once. cemetery, crematory or other place) Feb. ▼ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD Lorraine Park Cemetery 2010 Name and Address of Facility Signature of Fune al Service License 22. Name and Audi Barranco P.A. Severna Park Funeral Home Ritchie 495 Gov. Severna Park Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final On et and Do th Physician/ on 1 disease or condition resulting in death) Cul Medical Due to (or was consequence of) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Day Year n signed by the a Id be detached fo 9 Unknown 9 I IInknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 100 3 Probably 4 Unknown certificate has been si rector, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed 1 Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No director, Be 26. Place of Death (Check only one) Hospital Other: 잍 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Mother (Special After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 ☐ Yes Certificate: 28d. Describe how injury occurred Natural Injury 5 Pending Accident 2 No Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Gertifying Nurse Practioner: The best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 the only one) 29b. Signature apd P 29d. Date signed (Month. Day. Year) m NA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Day, State 32. R istrar's Signature FEB 1 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Patrick John Fischer, II Certificate of Death Registrar 2. Date of Death Decedent's Name (First, Middle,Last) Month Day February 14, 2010 Physician/ 0816 hrs Patrick John Fischer, II al Examiner 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Frederick Frederick Frederick Memorial Hospital If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Foreign Maryland
Country) 06/07/1982 Min. Months Days Hours 27 218-04-0202 1 M 2 F Director Usual Residence of Decedent 10d. Inside City Limits 10c, City, Town or Location 10a. State 10b. County 1 Yes 2 No Frederick Frederick Maryland 28a-f shov death with the Maryland 10g. Citizen of What Country? 10f Zip Code 10e. Street and Number 1048 Staghorn Avenue 21703 United States 14. Race - American Indian, Black, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Funeral 11. Marital Status 12. Was Decedent Ever in U.S. White, etc Armed Forces? X 1 Never Married 2 X Married 1 Yes 2 White 1 Yes 2 No specify: Specify: If Yes, Give Year ss 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene.

If item 27 is marked other than "natural", of her traumatic event, the Medical Examiner I 4 Divorced ੬ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) Construction Carpenter's Helper Baltimore, MD 21215-0036 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Antoinette Storm Patrick John Fischer Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Cod 19a. Informant's Name/Relationship (Type, Print) 1048 Staghorn Avenue, Frederick, Maryland 21703 Colleen B. Fischer/Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) permit. Pages 1
Department of H
Important: If ii 1 Burial 2 X Cremation 3 Removal from State Edgewater, Maryland 02/20/2010 Kalas Crematory Donation 5 Other Specify 22. Name and Address of FacilityGeorge P. Kalas unera fome 21. Sig style o eral ice Licenses 2973 Solomons Island Road, Edgewater, Would Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Between Onset and Physician failure. List only one cause on each line /Medical a. Multiple Gunshot Wounds Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed attending physician and for use as the burial - tran Physician/Medical UNPENDED AMENDED Records, P.O. Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: Year 23b Was decedent pregnant in the Day Fetal death 3 Ectopic pregnancy past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown signed by the a 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 ✓ No 3 Probably 4 Unknown ρ Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy death? performed' After this certificate has 1 Yes 2 No ✓ Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical Hospital or Attending Physician: Division of Vital Be examiner? Hospital: 1 Inpatient 2 PER/Outpatient 3 Other Nursing Home 5 Residence 6 Other DOA 1 🗸 Yes 28d. Describe how injury occurred 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Subject shot Certification: Feb 14, 2010 0740 hrs 1 Yes 2 ✔ No 1 Natural within 24 hours after death.

To the Funeral Director: A completely filled in by the fu Pending 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be 3 Suicide or Town, State) Himes Avenue & Ellison Court, Frederick, MD determined (Specify) Local Street 4 V Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 W Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier February 15, 2010 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Donna M. Vincenti, MD

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31 Date filed (Month Day Year) 2

32 Registrar's Signatu

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Health and Mental Hygiene 28b, e, f per me, g901,03/11/2010dhb Certificate of Death Reg. No. Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Olga R. Forcione Physician/ February 14, 2010 12:11 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Bethesda Suburban Hospital 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 579-01-9827 Funeral 1 □ м 2 🗓 F Months Days Hours Min 05/12/8/24917 Northy Carolina 92 Director Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location death with the Maryland 10d. Inside City Limits Director Bethesda MD Montgomery 1 X Yes 2 □ No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral United States 20814 9707 Old Georgetown Road #2613 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🗓 No Black, White, etc ģ 1 Never Married 2 Married filed within 72 hours after Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. "natural" Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. I other than " life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Federal Government Computer Specialist 4 of Health and Mental Hygier If item 27 is marked other in other traumatic event, the Be permit. Page 1 and 2 should be filee.
Department of Health and Mental Hw. Important If item 27 is markany injury or other. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ Minnie Rivers John Lambert 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 78 Willow Avenue Larchmont, NY 10538 19a. Informant's Name/Relationship (Type, Print) Erika Forcione / Niece 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 ☐ Cremation 3 ☐ Removal from State Silver Spring, MD Heaven Cemet. 2/17/2010 Gate of 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Joseph Gawler's Sons Inc. 21. Signature of Fundal/Service Licensee 5130 Wisconsin Ave. NW Washington, DC 20016 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition resulting in death) Respiratory Failure Medical Due to (or as a consequence of Examiner Anaphylaxis - Medication Adverse Reaction DANIC Sequentially list conditions, Examine ray, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Directo for as a sonascarense un been signed by the attending physician and should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Day 1 ☐ Yes 212 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Renal techen 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? CAF 24a, Was an After this certificate has funeral director, page 2: autopsy performed? 1 Yes 2 1 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be 1 XYes 2 □ No Hospital Other: ပ 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred iniury 1 Natural 5 Pending Unknown M 19/10 1 ☐ Yes 2 🔀 No 2 Accident 2 Medication Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number City or Town, State) **8600** 28e. Place of Injury - At home, farm, street, factory, office or Pura n | Route Number, | **Georgetown** | **Rd** determined building, etc. (Specify) Subuesano mo Medical 🛮 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier

To the Hospital or Attending Physician: within 24 hours a er death.

To the Funeral Director: After this certific Division of Vital

DHMH 17 Rev 7/2009

State

Registrar

only one)

29b. Signature and title

31. Date filed (Month, Day, Year)

FEB 18

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Andrew Wong, MD 8600 Old Georgetown Road Bethesda, MD 20814

Registrar's Sign

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29c. License number 066066

29d. Date signed (Month, Day, Year) 02/15/2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Lawrence Augustus Fells Sr A^{M} January 30, 2010 3:53 /Medical 4a, Facility Name (If not institution, give street and number) 4757 Chevy Chase Drive Apt. 205 4c. County of Death 4b. City, Town, or Location of Death Examiner Montgomery Chevy Chase If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 7/05/1914 5. Social Security Number 579-05-9035 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Min 1 1 XM 2 □ F Washington, DC Director 95 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Examiner must be notified at MD Montgomery Chevy Chase 1 ☐ Yes 2 No Director within 72 hours after death with the 10f. Zip Code 20815 10g. Citizen of What Country? United States 10e. Street and Number 4757 Chevy Chase Drive Apt. 205 'natural", or items 23a Funeral 12. Was Decedent Ever in U.S.
Armed Forces?
1 Tyes 2 No 5/1942
If Yes, Give
Year or Dates: 10/1945 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: Black þ 3 Widowed 4 □ Divorced Completed traumatic event, the Medical Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "n any injury or other traumatic event, the Meatl once. Elementary/Secondary (0-12) College (1-4or 5+) US Post Office <u>Postal Representative</u> 18. Mother's Name (First, Middle, Maiden Surname)
Anna Allen 17. Father's Name (First, Middle, Last) Be Thomas Fells ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |8908 Doris Drive Ft. Washington, MD 20749 Antoinette Jones-Black/Guardian 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) National Crematory Falls Church, VA Feb. 9, 10 21. Signature of Funeral Service Lion 22. Name and Address of Facility Joseph Gawler's Sons Inc. Wille 5130 Wisconsin Ave. NW Washington, DC 20016 23a. Part1. Enter the dise se, or complications by t aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Days Immediate Cause (Final **Physician** Urosepsis disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Years Bladder Cancer Sequentially list conditions, if any, leading to immediate cause. Enter University Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical as the IF FEMALE for use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) 9 Unknown ģ cate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 1 ☐Yes 2 No 1 ☐Yes 2 ☐ No funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 \sum Nursing Home 5 \subseteq 1 Residence 6 \subseteq Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 5 ☐ Pending investigation • Hospital or Attendii 24 hours after death. • Funeral Director: A etely filled in by the fu 1 ☐ Yes 2 □ No death. 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 THomicide To the Hospital within 24 hours a To the Funeral I completely filled 29a. Certifier 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29b. Signatur and title of gertifier 29c. License number 29d. Datę signed (Month, Day, Year) MD31516 10 10

State Registrar

31. Date filed (Month, Day, Year)

FEB 18 2010

DHMH 17 Rev 1/2001

#930 Chevy Chase, MD 20815

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michael Solomon MD 5530 Wisconsin Ave.

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 15^{ay} FEB. 20¹10 IRA DAVID FABER 7:03 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE MONTGOMERY . Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth Month, Day, Year) 1 M 2 F 151-32-4227 **Director** 66 PR Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☑ Yes 2 ☐ No MD MONTGOMERY GAITHERSBURG 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1001 BAYRIDGE 20878 TERRACE USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cyban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S.
Armed Forces?

1 ☑ Yes 2 ☐ Nol 9 6 3 —
If Yes, Give 1966 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: WHITE Completed 3 Widowed 4 Divorced Year or Dates. 1966 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) PARTS RUNNER AUTOMOTIVE 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည JACK FABER RUTH BLITZER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20878 19a. Informant's Name/Relationship (Type, Print) MAXINE FABER / SPOUSE 1001 BAYRIDGE TERRACE, GAITHERSBURG, Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) STAUFFER CREMATORY 2/16/2010 FREDERICK, MD 21. Signature of Fundal Service Lichnsee 22. Name and Address of Facility HILTON FUNERAL HOME P.O. BOX 86, BARNES 0/ 20838 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Pnysician ACUTE MYOCARDIAL INFARCTION disease or condition DAYS Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) physician a Physician/Medical Box 68760 the attending p as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death Yes 9 Unknown 9 Unknown P.0. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ HYPERTENSION Division of Vital Records, 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 \(\text{Yes} 2 No Other: မူ 1 X Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral or 27. Manger of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year, D0069129 FEBRUARY 15, MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JASON M. PRIOR, 9901 MEDICAL CENTER DRIVE, ROCKVILLE, MD 20850 MD

State

Registrar

31. Date filed (Month, Day, Year)

32. Registre 's Signature

enun

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, (Last) 2. Date of Death 3. Time of Death Physician/ Month Year OSEPH RIFFITH 2129 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death 12115 Maddox Lane Prince George's Bowie 8. Date of Birth (Month, Day, April 4 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Year) 1<u>932</u> Days Months Hours Min. Director 295-26-5209 77 Yrs. Usual Residence of Decedent 23a or 28a-f show er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12115 Maddox Lane 20715 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. was becedent Ever in U.S. Armed Forces?

1 □XYes 2 □ No
If Yes, Give
Year or Date\$\frac{4}{954-60} Black, White, etc. þ 1 Never Married 2 XMarried Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Completed 3 Divorced 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 alth and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 4 Photography U.S. Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ traumatic Lorine Elsworth Griffith Lois Proctor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important; If item 27 is any injury or any Barbara E. Griffith/Spouse 12115 Maddox Lane Bowie, MD 20715 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Marvland Veterans Cem; 2/25/2010 | Cheltenham, Maryland 21. Signature of Funeral Service Licen 22. Name and Address of Facility Beall Funeral Home NW Crain Bowie. 23a. Part 1. Enter the disease, or completions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only the colors on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury and I-transit that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day s been signed by the should be detached 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Records, 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an the Hospital or Attending Physician: The law autopsy page performed? Yes 2 No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 I 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 \square Pending work? after death.

Director: Aff
in by the fur 2 🗌 No Investigation Suicide Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certi 16 2010 4+1 Name and address of person who completed cause of death (Item 23a) Type, Print) ANNAPORT MID MYNI ENT W TIGHWAY State

DHMH 17 Rev 7/2009

Registrar

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month 3. Time of Death Year **Physician** 5:20 PM February 11, 2010 Byrne Gill Rita /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Holy Cross Rehab and Nursing Center Burtonsville Montgomery 8. Date of Birth (Month, Day, Year)
July 25, 1 5. Social Security Number **Funeral** Months Davs 1 □ M 2 🛛 F 1917Pennsylvania Director 578-60-6554 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10b. County show other traumatic event, the Medical Examiner rust be polified at 1 ☐Yes 2 No Director Maryland | Charles Waldorf 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 5 23a 4403 Quillen Circle 20602 USA permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23s any Injury or other traumatic event, the Medical Exaginant outs. Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 □Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2√□No 2 Specify: White 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Government Administrative Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas Byrne Rose Buckley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print)daughter 6225 Roblynn Rd., Laurel, Maryland 20707 Patricia Gill DiGiovanni 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cem. 2/20/2010 Silver, Spring, MD 22 Name and Address of Eacility
Fleck Funeral Home, INC.
7601 Sandy Spring Rd., Laurel, MD 20707 21. Signature of Funeral Service Licensee Mah MO1234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Years Immediate Cause (Final disease or condition resulting in death) **Physician** End-Stage Dementia /Medical Due to (or as a consequence of): Examiner Probable Renal Cancer Months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed Months Adult Failure to Thrive Due to (or as a consequence of): Box 68760. physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 months? Month Year 5 ☐ Other (specify) 1 ☐ Yes 2 No P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by Hypothyroidism, Parkinson's Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 2 **X**No 1 🗆 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending To the rusping after death.

To the Funeral Director: After the funeral by the full. 1 ☐Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c License number 2/16/2010 D 0065485 Superich, RSW MD

DHMH 17 Rev 1/2001

State

Registrar

MA

Barbara Supanich, 1500 Forest Glen Road, Silver Spring, Maryland

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FEB 17 2010

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2010 Physician/ February 6. Dorothy 12:45 P ^M Louise Garner Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 2208 Norlinda Avenue Oxon Hill Prince George's 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Alabama 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** (Month, Day, 1 M 2XX F Months Days Hours Min. 424-66-4275 64 1945 **Director** Aug. Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland must be notified at Director 1 🗌 Yes 2 🐺 No Maryland 1 Maryland Prince George's Oxon Hill 10e. Street and Number ŏ 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 2208 Norlinda Avenue 20745 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, P 1 Never Married 2XX Married Completed by ☐ Yes 2 XXNo Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2xx No Specify: Specify: 3 Divorced **Black** Year or Dates or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) years Administrator American University Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) h and Mental F 7 is marked of မ Dave Cherry Minnie Harrison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t of Health Crystal Gayle Garner / Daughter 2208 Norlinda Avenue Oxon Hill, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or Maryland Vet. Cemetery 03/05/2010 Cheltenham, Maryland 4 Donation 5 Other (Specify) 21. Signatur uner la ice Lice 22. Name and Address of Facility George P. Kalas Funeral Home P.A. 6160 Oxon Hill Road Oxon Hill, Maryland 23a. Plan. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Onset and Death Physician/ BREAST CANCER Medical resulting in death) Due to (or as a consequence of) Examiner KIDNEY FAILURE Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months? Month Day Year Pregnant at time of death g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2XXNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? Yes XX N To the Funeral Director: After this certifics completed filled in by the funeral director, I 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Hospital 2XX No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work 1 Tes 2 🗆 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 1XXCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinan: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nur rthe best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title 29d. Date signed (Month, Day, Year) February 9, 2010

DHMH 17 Rev 7/2009

State Registrar Iyan Zanya

9200 Basil Court #200 Upper Marlboro, MD

20772

on who completed cause of death (Item 23a) (Type, Print)

32. Registrer's Sign.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February 8, 2010 **Physician** Mildred Golder 7:30A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Andrus House Assisted Living N. Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, June 27, 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. Year Country) MA 1 □ M 2√2 F 021-09-9876 94 Ĩ915 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Medical Examinat must be notified at 1 ⊋Yes 2 □ No Director MD Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 6000 Berkshire Drive 20814 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ∐Yes 2 🛣No à If Yes, Give Year or Dates: Specify White Specify: 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental H Important: If item 27 Is marked oth any injury or other traumatic even Be Harry Rosenthal Florence Abramovitz 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul Golder - son 6000 Berkshire Drive Bethesda MD 20814 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Judean Mem. Gardens 02/21/2010 Olney, MD 4 Donation 5 Dother (Specify) Edware and Address of Facility Edward Ton Inc. 20852 21. Signature of Funeral Service Lie 23a Part 1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Stroke **Physician** disease or condition resulting in death) week /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) The law requires that the death certificate be executed Cause (Dicease or injuly that initiated events resulting in death) Last physician al Due to (or as a consequence of): Box 68760, Physician/Medical as attending properties for use as IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 0 the 9 Unknown signed by t ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, þ 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☒No 24a. Was an cate has I page 2 s autopsy performed? Yes 2 X No certificate ospital or Attending Physiclan: The hours after death.
uneral Director: After this certificate by filled in by the funeral director, pag 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 NOther (Specifyssisted Hospital: 1 ☐ Yes 2 🙀 No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital within 24 hours a

To the Funeral [29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) February 9, 2010 D26259 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 8218 Wisconsin Avenue Chevy Chase MD 20815 Ava A. Kaufman, 31. Date filed (Month, Day, Year) 2. Registrar's Signature State 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Jeanette Glover Glew February T4, 2010 4:06 р м Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 12503 Bushey Drive Silver Spring Montgomery . Social Security Number If Under 1 Year If Under 24 Hrs 6 Sex Funeral 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 1 F Days Hours July 23, 1954 534-60-7159 55 Director Yrs Washington Usual Residence of Decedent shov 10a. State 10b. County with the Maryland iral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🎦 No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12503 Bushey Drive 20906 USA hours after death 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ☐ No Specify: "natural", Completed 3 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) oa. Decedents Subla Occupation
(Give kind of work done during most of working
life. DO NOT use retired)
Supervisory Consumer Safety
Officer 72 than, College (1-4 or 5+) 5+ Elementary/Seconday (0-12) permit. Page 1 and 2 should be filed with.
Department of Health and Mental Hygiene Important: If item 27 is marked other this any injury or other traumatic enterminations. Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Robert Glover Estelle Langford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Raymond E. Glew, III/Husband 12503 Bushey Drive, Silver Spring, MD 20906 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Feb. 16 1 Burial 🍇 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 2010 Alexandria, Virginia Signature of Funeral Service Licensee 22 Name and Address of Facility
Francis J. Col
500 University lins Funeral Home Blvd. W., Silver Inc. Spring, MD 20901 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, otheart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ ASHD disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner per tension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as consequence of) Cause (Disease or iinjury that initiated events or Attending Physician: The law requires that the death certificate be executed the attending physician and Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No 4 ☐ Pregnant 9 ☐ Unknown Month Pregnant at time of death Day Year ate has been signed by the a page 2 should be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ diabetes Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖼 Unknown dolesters 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed?

1 Yes 2 No Director: After this certificate of in by the funeral director, pag 1 Yes 2 🗆 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural iniury 5 Pending 1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Hospital within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

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32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c License number

m 29018

Dr. Batsy

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1 _ State	ryland / Depa	artment of He		, ,	(D. (D. 1		
* 45		Registrar 1. Decedent's Name (First, Middle, Last)	Cei	illicate of D	eaui	2. Date of Death	Reg. No. 2 3. Time of Death		
Physic	ian					Month Februar	Day Year		
/Medi		Richard O. Hastings 4a. Facility Name (If not institution, give street and number)		4b. City, Town, or L	ocation of Death	reblual	4c. County of De		
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Funeral			(In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. E	Birthplace (State or Foreign	
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or 24	Director	10e. Street and Number		10f. Zip Code		10	g. Citizen of What	Country?	
ath w	<u>a</u>	136 Harford Road		21801			U.S.A		
er de Items	Funeral	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married 1 ☒ Yes 2 □ N	ver in U.S. 13.	Was Decedent of Hisp f Yes, specify Cuban,	panic Origin? (Sp Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ar Black, W	nerican Indian, hite, etc.	
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A I A I S-0030 d within 72 hours af giene. er than "natural", or the Medical Examl	ed	15. Decedent's Education		dent's Usual Occupati	on	1	6b. Kind of Busines		
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with jiene	Completed	Elementary/Secondary (0-12) College (1-4or 5+		etter Carr	ier		Postal	Service	
other fent,	Be C	17. Father's Name (First, Middle, Last)	•	1	8. Mother's Nam	e (First, Middle, M	laiden Surname)		
Id be Alenta Iked Itic even	TO B	Norman Thomas Hastings			Gertie	Figgs			
Mad yidilid ZIZI3-UU30 d 2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. It is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (Type. Print)	19b. Mailin	ng Address (Street an	d Number or Rui	al Route Number,	City or Town, State	, Zip Code)	
= p = 2:		Shirley Martin (Sister)	136 I	Harford Ro	ad Sal	lisbury,	MD 2180	1	
dillinore, mit. Pages 1 ar partment of Hea portant; If Item y Injury or othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	20b. Place of Dispo cemetery, crer	sition (Name of natory or other place)	1	Date 2	0c. Location - City	or Town, State	
Pag nent ant; I		4 □ Donation 5 □ Other (Specify)	St. Stephe	ens Cemete	ryFeb. 1	8, 2010 D	elmar, D	elaware	
		21. Signature of Funeral Service Licensee	22	Name and Address Short Fun	of Facility	ne.			
0 88 5 5		Grup Thortolews		13 East G			mar, DE	19940	
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To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate hat completely filled in by the funeral director, page		29a. Certifier (Check only 2 Medical Examiner: On the basis of	f my knowledge, death	n occurred at the time	, date and place,	and due to the ca	use(s) and manner	as stated.	
the Prin 24 the Fruger	fedical	and manner state	ed.						
5 ¥ 2 E	Σ	29b. Signature and title of certifler	-	29c. License r	number	29	ld. Date signed (Mo	onth, Day, Year)	
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U		Mahesha Thimmarayappa, MD 31. Date filed (Month, Day, Year) 32. Refistra	r'o Cianaturo	ern Shore	Drive,	Salisbur	y, MD 218	04	
Sta Regist	ate rar	FEB 18 2010	M. A.	back					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Halas Lola Margaret 2010 6:23 P Feb Medical 4a. Facility Name (if not institution, give street and number) Examiner Center 4b. City. Town, or Location of Death 4c. County of Death Anne Arundel Severna Park Genesis HealthCare Severna Park Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 212-22-5689 1 □ M 2 🛛 F Months Days Hours Sept. 17, 1917 V<u>irginia</u> 92 Yrs. **Director** Usual Residence of Decedent 28a-f show 10a. State aţ 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified Arnold MD Anne Arundel 1 Yes 2 XNo 5 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 23a Funeral 785 North Lakeview Drive 21012 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Black, White, etc "natural", or ğ 1 Never Married 2 Married 1 Yes 2 XNo If Yes, Give White 1 ☐ Yes 2 X No Specify: Specify: Completed 3 X Widowed 4 Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) than " John Halas Elementary/Seconday (0-12) College (1-4 or 5+) the Welding Company 12 Secretary other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ဂ္ John Henry Joseph Boggs Leah Hubbard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ellis L. Kincer / Son Health item 27 785 North Lakeview Drive Arnold, MD 21012 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or ott Feb. 22. 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) New Cathedral Cemetery 2010 Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home Hwy, Severna Park, MD 21146 495 Gov. Ritchie h. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, k, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ preumonia disease or condition dai Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical that the death certificate be IF FEMALE: nse 23b. Was decedent pregnant 23d. Date of delivery for in the past 12 months? Month Day 5 Other (specify) Pregnant at time of death signed by the a d be detached f Yes 2 LNo 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Pinknown funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Physician; The law has autopsy performed Yes 2 N 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 No Other: 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred or Attending 1 atural injury 5 Pendina work? 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A Accident Investigation completed filled in by the 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check To the I within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, plo ame and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar

Baltimore, Maryland 21215-0036

68760

Box

Records,

Division of Vital

1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 4 ▼ Nursing Home 5 □ Residence 6 □ Other (Specify) 28d. Describe how injury occurred Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or inventioning in the cause of examination and or inventioning in the cause of examination and/or inventioning in the cause of examination and or invention and or inventi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License numbe 29d. Date signed (Month, Day, Year)

Month

Day

8:40 p.

9. Birthplace (State or Foreign

10d. Inside City Limits

Yes 2 No

Louisiana

white

21702

Interval Between

Onset and Death

3 WEFK

Black, White, etc.

Registrar

Medical

Hirem Shaw, MD 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

determined

☐ Homicide

29a. Certifier (Check

29b. Signatur

only or

65 C Thomas Johnson Drive, Frederick, Maryland 32. Registrar's Signature

DHMH 17 Rev 7/2009

24 hours

To the within 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No.... 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 3:57 P M February 15, 2010 Mary Lucille Hall 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day,) 1/3/1936 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthday) Social Security Number Months Days Hours Min 1 □ M 2 😾 F 74 216-32-8411 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 □Yes 2X No Maryland | Anne Arundel Davidsonville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 227 Brick Church Road 21035 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 No Was Decedent of Hispanic Orlgin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 Never Married 2 ☐ Married If Yes, Give Year or Dates: 1 ☐ Yes 2 🛣 No White Specify 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Salesperson Retail 11th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Jessie Lee Hooper George Matthew Hall 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Davidsonville, MD 21035 227 Brick Church Rd., Linda J. Hall/ Sister 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State St. Mary's Cemetery 2/22/10 4 ☐ Donation 5 ☐ Other (Specify) Annapolis, MD 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence ultiloba Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. ropen 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an 1 ☐ Yes 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred

Physician /Medical Examiner

Physician

/Medical

Director

Funeral

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Completed

Be

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Examiner

Funeral

Director

item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the "medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Manna in injury or other traumatic event, the Manna

hours after death

Baltimore, Maryland 21215-0036

Examiner

physician and s the burial-trans as 1 attending properties for use as cate has been signed by the page 2 should be detached certificate

The law requires that the death certificate be executed

Box 68760,

P.0.

Division of Vital Records,

the Hospital or Attending Physician:

Physician/Medical 2 Completed

Be Certification: To hin 24 hours after death.

the Funeral Director: After this on the fulled in by the funeral dir

<u></u>	hronicl	Jm	-
25.	Was case referred examiner? 1 ☐ Yes 2 ☐ No	medical	

1 Natural

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

27. Mann of Death

5 Pending investigation 2 Accident

6 Could not be determined

28b. Time of Injury 28a. Date of Injury (Month, Day, Year)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Signature and title of certifie

D0005

29c. License number

29d. Date signed (Month, Day, Year)

(Item 23a) (Type, Print) 30. Name and address of person who completed cause of deal 31. Date filed (M

and manner stated.

State Registrar

10

Medical

2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death February 20, 2010 **Physician** Irvin Arlev Hutchinson, Jr. 7:55 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 14711 Pennsylvania Avenue Hagerstown Washington If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 8. Date of Birth (Month, Day, May 7, 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 1 □**X**M 2 □ F 7. Age (In yrs. last birthday) **Funeral** West Virginia 1953 Director 236-86-6032 56 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits show 2 should be filed within 72 hours after death with the Marylar and Mental Hygiene. In an and Mental Hygiene. In an arked other than "natural", or items 23a or 28a-f show marked other than "natural", or items 23a or 28a-f show maric event, it is Novileal Exeminant to rottlind an raumatic event, it is Novileal Exeminant. 1 ☐ Yes 2 X No Director Maryland Washington Hagerstown 10g. Citizen of What Country? 10e. Street and Number 21742 14711 Pennsylvania Avenue U.S.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Wes 2 No 197 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. 1970-1 Never Married 2 Married 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: 1973 White Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Owner and Operator Landscaping 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 12 should be fi th and Mental I Irvin Arley Hutchinson, Sr. Marian Piper or other traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is any injury or other trau Faith M. Esworthy / Daughter 14711 Pennsylvania Avenue Hagerstown, MD 21742 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burlal 2 【☐ Cremation 3 ☐ Removal from State Stauffer Crematory 4 ☐ Donation 5 ☐ Other (Specify) 02/25/2010 | Frederick, Maryland 22. Name and Address of Facility Bast-Stauffer Funeral Home, P.A. 21. Signature of Funeral Service Lice 7606 Old National Pike Boonsboro, Maryland 21713 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Repatocellular 8 months carcinoma /Medical Due (or as a consequence of): Examiner Circhosis of the Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Listance of the initiated events resulting in death) Last Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit requires that the death certificate be executed thepatitis Years Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month signed by the a 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, <u>გ</u> 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Pancy topenia Completed 24b. Were autopsy findings available prior to completion of cause of death? atrial Fibrillation 24a. Was an cate has t nis certificate hadirector, page performed? 1 ☐ Yes 2 ☐ No 2 🗆 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p. 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐Yes 2 ☐No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) February 22, 2010 Cynthia Kuttner-Sands, mo D47451 747 Northern Avenue 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cynthia Kuttner-Sands, MD Hospice of Washington County 1-H C Hagerstown, Maryland 21742 31. Date filed (Month, Day, Year) FEB 2 3 32. Registrar's Signature State 2010 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2 **Physician** Anna Mae Holden 2010 3:40 A 16 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 12010 Atlantic General Hospital Berlin Worcester If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 □ M 2 🔀 F Months Days Hours 214-03-4460 89 **Director** 3/19/1920 MD Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits show 10b. County item 27 Is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the "Notical Examiner must be notified at Director 1 ☐ Yes 2 🙀 No Worcester Berlin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21811 12318 Snug Harbor Rd. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 □Yes 2X No Specify: þ Specify. 3 X Widowed 4 □ Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Bernard Selby Anna Mae Travers ပို 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Johnson - Willis/daughter 11402 Quillin Way, Berlin, MD 21811 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of the Important: If ite any Injury or ot 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sunset Memorial Park | 2/19/2010 Berlin, MD 21. Signature of Funeral Service bicensee 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on + och line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical r as a consequence 🚁 Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner sician and burial-trans Due to (or as a consequence of): Physician/Medical for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Day in the past 12 months? Month Year 5 ☐ Other (specify) 1 ☐Yes 2 ☐NO detached Ö 9 ☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Records, Se o 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ onknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 ☐ Yes 2 ☐ No Vital 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 LV Medical Certification: To ot 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Matural 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? or Attending 5 Pending Anny 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after deatl To the Funeral Director: 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 29a, Certifie 1 Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, 29b. Signature and title of cert 30. Name and address of DI 10 31. Date filed (Month, Day, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For AMEND#6perFH,2/19/10,BW,MCo Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 Feb. 13, C. Hill 5:45a Robert Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Rockville Collinswood Nursing Home Montgomery 5. Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 229-44-8423 1X M 2 😾 Months Days Hours Min. Wash. **Director** ,D.C. Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Gaithersburg MD Montgomery 1 Yes 2 X No 10f. Zip Code 10g. Citizen of What Country? Funeral 19443 Brassie Place #103 USA 20886 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14 Bace - American Indian Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married Yes 2 ₩ No Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: If Yes, Give White 3 X Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) General Elementary/Seconday (0-12) College (1-4 or 5+) Contractor Self employed 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Ernest Hill Ethel Compton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 92019 Suzanne M.Murray/Niece 12137 Via Antiqua El Cajon, California 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place, Burial 2 ☐ Cremation 4 Donation 5 Other Soc ☐ Removal from State National Mem. Pk. 2/19/2010 Falls Church, Va. Signature Full eral 3 THITTP ACCESSINALDI FUNERAL SERVICE, P.A 9241 Columbia Blvd.Silver Spring,Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) *Medical Due to (or as a consequence of Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Year Pregnant at time of death 5 Other (specify) Month Dav 1 L Yes 2 L 9 Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 🌠 No Be 26. Place of Death (Check only one) Hospital Other: မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b, Time of 28d. Describe how injury occurred 1 🔄 Natural 5 Pending injury 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 🙎 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗌 29b, Signature and title of certific 2 29c. License numbe 29d. Date signed (Month, Day, Year)

State Registrar Registrar's Signat

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5 A 4 E D E S A 4 4 A 2 10 11 6 Mag

Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

_			1 - For State Amended#14p	State of Marylan erFH FCHD KS 2/	d / Departr 23 / Pe <i>rtifi</i>	nent of	Health ar	nd Mental H	ygiene	1.0	0.4=0
	Physi	ion	 Decedent's Name (First, Middle.) 	Last)	2. Date of D	Reg. No.		0653			
7	Physi Me	cıan/ dical	Robert Milto	n Holland		Month	Day	Year	3. Time of Death		
	Exan	niner	4a. Facility Name (if not institution, g	give street and number)	4b.	City, Town, c	or Location of D	<u>Februa</u>		2010	7:55p M
			Frederick Memor	ial Hospital			erick		4c. County		. 1
	Funer Directo		5. Social Security Number	Sex 7. Age (In yrs. Ia	Mor	nder 1 Year	If Under 24		irth	eder	LCK lace (State or Foreign
			215-20-9065 Usual Residence of Decedent	83	Yrs.	uis Days	Hours	Jan. 2	7, Year) 7, 1927	Count	y) vland
	shov	þ		10c. City	, Town or Location						
	Mary 28a-f otifie	Director	Maryland Frede							10	Od. Inside City Limits
	h the	<u></u>	10e. Street and Number	Adam Adam	stown 10	. Zip Code			10- 04		1 Yes 2 No
	h with	Funeral	2832-B Park Mill:	s Road		2171	0		10g. Citizen of V		.,.
	r iten		11. Marital Status	12. Was Decedent Ever in U.S.	13. Was D	cedent of H	ispanic Origina	(Specify Yes or No-	United	Stat - America	
326	al", o	d by	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 □ No If Yes, Give	ii ies,	specity Cuba s 2 🙀 No	in, Mexican, Pu	erto Rican, etc.)	, ,, , , ido.	k, White, et	C.
5	hours	ete	15 Decedent's	Year or Dates. Korea	n				Specify:	Blac Whit	
21215-0036	in 72 e. ian "r	Completed	(Specify only highest Elementary/Seconday (0-12)	grade completed)	16a. Decedent's I	work done d	ation <i>luring m</i> ost of v	vorking	16b. Kind of Bu		
	withi giene ger th		8	College (1-4 or 5+)	iiie. DO NOT	orer	ı				
n d	tal Hy	o Be	17. Father's Name (First, Middle, Last)		rer	18 Mother's N	Name (First, Middle,	Const	<u>ructi</u>	on
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Maryland	shour and ris m		19a. Informant's Name/Relationship	Type, Print)	19b. Mailing Add	ess (Street a		Rural Route Numbe	r City or Town Ca	7: 0	
	and 2		Mildred Holland/	Wife	2832-B 1	ark M	ills Ro	ad, Adam	ctors Mar	ate, ZID Co	ae)
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Baltimore.	it. Pa rtmer rtant njury		4 ☐ Donation 5 ☐ Other (Spec	ify) Hope	Hill Cer			0/2010			
Ba	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licer	isee /	22 Name	and Address	- 6 = - 1114		Adamsto	m. Ma	aryland.
			23a Boot 1 February	voper	1621	Opossi	uneral umtown	Homes P. <u>Pike</u> , Fre	A. ederick.	Marv	Land 21702
	D 1		23a. Part 1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final	nplications that caused the death. I one cause on each line.	Do not enter the m	ode of dying,	such as cardia	ac or respiratory arr	est,	A	pproximate
	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a Aa	nal f	rspin	ction			Ç	nset and Death
	Examiner		•	Due to (or as a consequen	ce of):	1				- 1-77	gurs -
		je	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequen							
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8760		Me	F FEMALE:							_	
Box 68	Attending Physician: The law requires that the death certific redeath. ector. After this certificate has been signed by the attending by the funeral director, page 2 should be detached for use as	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy					204 D-4		
Bo	the at	/sic	1 Ves 2 No	4 Pregnant at time of deat	h 5 Other	pregnancy spec <i>ify)</i>			23d. Date Month	,	y Year
P.O.	at the	F.									
G,	signe	g	Part II. Other significant conditions of	ontributing to death but not resulting		cause given	in Part I.	23e. Did tob	acco use contribu	ite to the ca	ause of death?
ord	v require s been sig should b	etec	No. of the second	JOILEN DIS	sease			1 □ Y€	es 2 🛣 No 3	☐ Probabl	y 4 🗆 Unknown
Records,	has law	립						24a. Was ar	24b. Wei	e autopsy	indings available
<u>m</u>	sician: The la certificate ha rector, page		E Was and a second					autops perform	ned? I dea	r to comple th? Yes 2X	etion of cause of
/ita	Physician: this certific ral director,		5. Was case referred to medical examiner? 1 ☐ Yes 2 👿 No	Hospital:			of Death (Che		1 1 1 1 1	res ZA) NO
of Vital	g Phy er this eral d	<u>ှ</u> င် ဥ	7. Manner of Death	1 X Inpatient 2 ER/			4 Nursing F	lome 5 Reside	nce 6 Other (S	Specify)	
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Division	Atte er de ectol		3 Suicide 6 Could not be determined	28e. Place of Injury - At home,	farm street feeter		2 🗆 No				
Οį	tal or rs aft al Dir ed in		determined	building, etc. (Specify)	iami, street, iactor	у, описе		28f. Location (Stre City or Town,	eet and Number of State)	Rural Rou	te Number,
	t hour thouser and fill be	Medical	9a. Certifier 1 X Certifying Phys	cian: To the best of my knowledge er: On the basis of examination and	e, death occured at	the time da	te and place o	nd due to the	-/		
;	Io the Hospital or Attending Phy within 24 hours after death. To the Funeral Director: After this completed filled in by the funeral di		only one) 3 Li Certifying Nurse	er: On the basis of examination and erractioner: To the best of my known	or investigation, in	my opinion, d	leath occurred a	at the time, date and	e(s) and manner as place, and due to	s stated. the cause(s)	and manner stated.
	Vit To	29	b. Signature and title of certifier			. License nui	T, ante and plu	oc, and due to the c	ause(s) and manne d. Date signed (M	r as stated.	
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to	t	30	. Name and address of person who co	mpleted cause of death (Item 23a)	(Type, Print)				ebruary	1/, 2	.010
Ų.		M	ichael A. Tolino I Date filed (Month, Day, Year)	4D 1475 Taney Av	enue, Fr	ederic	k, Mar	vland 217	02		
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DHMH 17 Rev 7/2009

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State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ FEBRUARY 2010 6.24 Рм MICHAEL WARNER HAHN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death FREDERICK FREDERICK FREDERICK MEMORIAL HOSPITAL 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs, last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Days 1-9-1968 1 XM 2 □ 42 Director 219-98-0637 Usual Residence of Decedent should be filed within 72 hours after death with the Maryland 10a. State 10b, County ms 23a or 28a-f sho must be notified at 10c. City. Town or Location 10d. Inside City Limits Director MD Frederick Frederick 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21701 **USA** 305 Birmingham Court 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Unemployed N/A Be other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) nd Mental F Milton Hahn Sr. Doris Elizabeth Kemp Health and I 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Milton Hahn Sr. Father 502 K Leahy Court Frederick, Maryland 21703 Page 1 and 2 Department of Heal Important: If item 2 any injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State Smithsburg, Cremation 2-22-2010 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg, Maryland Signature of Funeral Service Liq 22. Name and Address of Facility Keeney & Basford P.A. F.H. 106 East Church Street Frederick, Maryland 21701 M01176 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest ock, or heart failure. List only one cause on each line Immediate Cause (Final and Death Physician/ disease or condition resulting in death) KES Medical Due to (or as a o **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Certificate: To Be Completed by Physician/Medical Examiner attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Hypotension, Hepatic Encephalo pathy, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Metabolic Acidosis, Kurnia, Ascites, Conquiopathy 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 1 Minpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a To the Funeral L Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifie H0068505 20,2010 ebrian son who completed cause of death (Item 23a) (Type, Print) Frederick, Mi 400 Registrar's Signatur State Registrar

DHMH 17 Rev 7/2009

DHMH 17 Rev 1/2001

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State

Registrar

31. Date filed (Month, Day, Year)

MAR 0 4 2010

Box 68760

P.0.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year 2_Month **Physician** Kenneth Eugene Harding 0 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Hagerstown Washington County Hospital 8. Date of Birth Month, Day, Yea July 16, If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 5^{Year)}1938 Hours Days 1 √ M 2 □ F Maryland 71 215-34-2719 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State r than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at 1 XYes 2 No Director Washington Hagerstown Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21740 121 Broadway, Apt. 1 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify: Completed by 3 Widowed 4 X Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within the and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Construction Brick Layer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Sallie K. West t and 2 should by Health and Ment Oliver B. Harding, Sr. 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trai once. 121 Broadway, Apt. 1, Hagerstown, MD 21740 Nancy E. Geiger, Friend 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Mount Olivet Cemetery Feb. 25, 2010 Frederick, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Keeney and Basford PA Funeral Home Richo M00255 106 East Church St., Frederick, MD 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ne men /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any least of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last rest wied Examiner or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) the detached a ☐ Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Pres 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed certificate 2 □-No director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Natural Jan 31.206 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 2300M within 24 hours after deat To the Funeral Director: filled in by the 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Gity or Town, State) 4 ☐ Homicide Hospital 24 hours a LW Cy - House 169

State Registra

29a, Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month. Dav. Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

751 32. Regi trar's Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year,

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Vear Month Physician 2-19-2010 Doris M. 3:00 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Northampton Manor Care Frederick Frederick 8. Date of Birth (Month, Day, Year) 12/14/1928 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under **Funeral** Days Min 1 □ M 2 🕅 F 81 212-24-2826 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10d. Inside City Limits 10c. City, Town or Location 10a. State 28a-f show la or 28a-f show the notified at 1 ☐ Yes 2 No Director MD Frederick Frederick 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number 21701 United States 282 Pinoak Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ∐Yes 2 1 No If Yes, Give Year or Dates: 1 Never Married 2 Married or i Baltimore, Maryland 21215-0036 1 □Yes 2√√2 No Specify. 2 Specify: white 3 ₩ Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) federal gov't accounting dept. 7 is marked other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) Be (17. Father's Name (First, Middle, Last) John William Burke Nettie Virginia Wright ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 11 Rosewood Ct., #313, Woodsboro, MD 21798 Deborah Santelli/ daughter Department of Health Important: If item 27 any Injury or other trong. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) Providence Cem. 2/24/2010 Kemptown, MD 22. Name and Address of Facility Keeney & Basford P.A. F.H. 21. Signature of Funeral Service Licenses MO1222 106 East Church Street Frederick, MD 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and burial-tra Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the burial Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 4 Pregnant Pregnant at time of death 5 Other (specify) ned by the a 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 ☐ Unknown 1 Tyes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 1 TYes director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 2 ER/Outpatient 3 DOA Certification: To 1 Inpatient funeral 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

filled in by the 24 hours a Funeral I completely within 2

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) 29b. Signature and title of certifier

and manner stated.

29d. Date signed (Month, Day, Year)

30. Name and address of per on who completed cause of death (Item 23a) (Type, Print

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State Registrar

Medical

31. Date filed (Month, Day, 32. Registrar's Signature

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r S			Carroll Hospital Center 5. Social Security Number 6. Sex 7. Age (In yrs. la.					If Unde	r 1 Year	inster If Under 24 Hrs.	8. Date of B			rthplace (State or Foreign	
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Mar			19a. Informant's Name/Relationship (Type. Print) Randy Ripley Nephew 19b. Mailing Address (Street and Number or Rural Route Number, Cit 20 Sheppards Ln Sykesville Mary)												
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o	Physic this co	은	1 Pres 2 No	Hospital: 1 28a. Date			ER/Outpatie		Oth 28c. Injur	4 🗀 Nursing F	lome 5 Re		6 □Other (Sp	pecify)	
Division of Vital Records,	l or Attending Ph after death. Director: After th I in by the funeral	Certification:	27. Manner of Death 1 ☐ Natural 5 ☐ Pendin 2 ☑ Accident invest	/4.4-		iy, Year)	Injury	7 M	Wor	k? Yes 2 ⊡No	1 2 .		of be	ed	
Visi	Atter er dea ector by the	tifica	3 Suicide 6 Could 4 Homicide deterr	not be nined 28e. Place	e of Inj	ury - At ho	me, farm, st	reet, factor	ry, office		City or T	own. Sta	ite)	Rural Route Number,	
25. Was case referred to medical examino? 1															
								ind place, and d	lue to the cause(s)						
29c. License number 29d. Date signed (Month, Day, Ye															
			> CIRC	This /	1),1	VV	VX		06	4408	00051924	2/	26/2	010	
			30. Name and address of person AJAY BEHARY.						AI/E	1 11-0	ALLBEC	+=70	MA	21150	
	Sta	ate	31. Date filed (Month, Day, Year	32	Registi	rar's Signa	ture	170	1	WEST	701110	1016	10113 00	(1)	
	Registi		MAR 04	2010 2	un	N	2. A								

DHMH 17 Rev 1/2001

Scott	Allan	Hutchinson
00011	, man	T Tu to till 13011

2	0	Removed by	0	1)	6	5	3	-

		1- For State C6 Registrar	ertificate of Death	Reg. No.	
Physici	an/	Decedent's Name (First, Middle,Last)		Date of Death Month Day Year	3. Time of Death
ীical Exam	iner	SCOTT AILEN HUTCHISON	<i>)</i>	February 23, 2010	1308 hrs
7		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		
		Baltimore Washington Medical Center	Glen Burnie	Anne Arundel	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs.	last birthday) If Under 1 Year If Under 24Hrs Months Days Hours Min.	Forei	
Director		219-88-2944 18M 20F L	Yrs. World's Days Hours Will.	18-11-62 C	BERMANY
,		Usual Residence of Decedent			, , , , , , , , , , , , , , , , , , , ,
w any		Α	y, Town or Location		10d Inside City Limits
Maryland 28a-f show 1 at once.	ō	MD, ANNEARUNDE	SEVERN		1 Yes 2 No
Mary 28a-	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Cou	ntry?
h the 3a or otifie	Ö	1931 STONE CASTLE DR.	21144	U.S.A	. •
h wit ems 2 t be n	era	11. Marital Status 12. Was Decedent Ever in the Armord Formus 2	J.S. 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto		ican Indian, Black,
r deat or it	Funeral	1 Yes 2 No			•
15-0036 filed within 72 hours after death with the Maryland I Hygiewi I Hygiewi than "matural", or items 23a or 28a-faho t, the Medical Examiner must he notified at once	þ	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1 Yes 2 No specify:	Specify	ITE
hour natu	eted	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	16a. Decedent's Usual Occupation (Give kind of v during most of working life. DO NOT use reti		industry
36 hin 72 than '	ble	College (1-4 of 5+)	D	QUARK	· V
5-0036 iled within 77 Hygiene. I other than	Comple	17. Father's Name (First, Middle, Last)	DUMPTRUCK DRIVER 18.Mother's Name	(First, Middle, Maiden Surname)	` 1
21215-0036 Uld be filed within 7 Mental Hygiene. marked other than	Be C	Paul E Hutchison	Dollie		
2121 2121 Ould be fi Mental I marked	To E	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or F		, Zip Code)
she and 7 is	_	DEBORAL HUTCHISON, WIFE	1931 STONE CASTLE DRIVE.	SEVERNIND, ZIIUL	t .
e, M l and 2 Health item 2		20a. Method of Disposition 20b.	Place of Disposition (Name of cemetery, crematory or other place)	Date 20c. Location - City or	
Fr of S of		1 Burial 2 Cremation 3 Removal from State	Annual Carrier place)	1-10 0	MD
Baltimore permit. Pages 1: Department of H. Important: If it injury or other t		4 Donation 5 Other Specify: 21. Spinafure of Funeral Service Licensee	22. Name and Address of Facility	SHERTY FUNERAL	Har. E
Balt permit Depart Impor injury	C	17. 1 M00947	2601 MOUNTAINED A	SADENA MD. Z1127	•
Physician		23a. Part I. Enter the disease or complications that caused the deat failure. List only one cause on each line.	h. Do not enter the mode of dying, such as cardiac o		Approximate Interval Between Onset and
//Medical Examiner		Immediate Cause (Final disease a. Acute pancrea			Death
LAdilliller		or condition resulting in death) Due to (or as a consequence			
	<u>_</u>	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence	oft.		
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	51).		
d d	xar	events resulting in death) Last Due to (or as a consequence	of):		
executed an and al - transit		d.			
- 0 .2 .5	/Medical	X UNPENDED AMENDED 23a,PII,27	, G902 4/16/10 TT		
76 icat		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pre	gnancy	23d. Date of deliver	
Sox 68' leath certiff e attending for use as it	ciaı	past 12 months?		Inc)	Day Year
Box 68: death certif the attending	Physiciar	1 Yes 2 No 9 Unknown			
Records, P.O. Box 68 The law requires that the death certiful are the law requires that the death certiful age to should be detached for use as		Part II. Other significant conditions contributing to death but not	resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to	
signe	d by	Chronic alcohol abuse; Hyper	tensive atheroscleortic	1 Yes 2 No 3 Prol	oably 4 🗸 Unknown
ords, w requir	Completed	_cardiovascular disease			topsy findings available completion of cause of
Reco The law cate has	omp			performed? death? 1 ✓ Yes 2 No 1 ✓ Ye	es 2 No
<u> </u>		25. Was case referred to medical	26.Place of Death (Check of		
of Vital Records, ng Physician: The law requir After this certificate has been s neral director, page 2 should I	To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2	ER/Outpatient 3 DOA Other Nursin	g Home 5 Residence 6 Othe	•
fing Ph		27. Manner of Death 28a. Date of Injury	28b. Time of Injury 2Bc. Injury at Work?	28d. Describe how injury occurred	
ion feath. or: /	atio	1 Accident Investigation (Month, Day,Year)	1 Yes 2 No		
Division tal or Attendi rs after death. al Director: //	ific		nome, farm, street, factory, office building, etc.	28f. Location (Street and Number or Ru or Town, State)	ral Route Number, City
Division of Vital optial or Attending Physician: house after death. meral Director: After this certif by filled in by the funeral director.	Certification:	4 Homicide determined (Specify)		or rown, state,	
E 72 A B		(Orleck Only	dge, death occurred at the time, date and place, and		
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical	and manner stated.	and/or investigation, in my opinion, death occurred a		
	Σ	29b. Signature and title of certifier	29c. License number	29d. Date signed (Mo	
		MIL ~ M	O.C.M.E.	February 24, 20	U
		30. Name and address of person who completed cause of eath (Iter		7 21201	
		Russell Alexander MD. Assistant Medical Exal 31. Date filed (Month, Day, Year) 32. Registrar's Signa		2 2 1 2 0 1	
S Regis	tate trar	31. Date filed (Month, Day, Year)	A BONES OCME		

		■ State		epartment of H Certificate of D			2010	06538
		Registrar 1. Decedent's Name (First, Middle, Last)		ertificate of L	eaur	Re 2. Date of Death	g. No.	3. Time of Death
Physic Med	cian/ dical	Pamala Larue Tones				February		22:20 PM
Exam	niner	4a. Facility Name (if not institution, give street and number) Union Hospital of Cecil Cou	nty	4b. City, Town, or E1kton	Location of Death		4c. County of Deat	
Funera Directo			(In yrs. last birthda 49 Yrs	Months Davs	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Bay, Y	9. Birt 1960 Wise	hplace (State or Foreign
nd how at	٦,	Usual Residence of Decedent 10a, State 10b, County	10c. City, Town or	Location				10d. Inside City Limits
larylar 3a-f sl	15	Maryland Cecil		ton				1 ☐ Yes 2√√ No
the M or 28	2	10e. Street and Number	EIK	10f. Zip Code		10	g. Citizen of What Co	
with Is 23a	Funeral Director	38 Rock Creek Drive		21921			United Sta	ates
ING 21213-UU36 filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at.	2	1 Never Married 2 Married 1 Yes 6 to 1	er in U.S. 1	3. Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2 🛣 No	n, Mexican, Puerto	cify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: Who	e, etc.
2 hou "natu	1	15. Decedent's Education (Specify only highest grade completed)	(Gi	cedent's Usual Occupa		ng 1	6b. Kind of Business	ndustry
rithin 7	Completed	Elementary/Seconday (0-12) College (1-4 or 5+) life	memaker	v		Own Hor	n A
be filed w ental Hyg ked othe	å	17. Father's Name (First, Middle, Last)		memaker	18. Mother's Name	e (First, Middle, Ma		ile
ylar ylar ld be i Menta arked	٩	Rufus West			Reeb1e	Whitake	r	
y, Maryiand nd 2 should be filed ealth and Mental Hy n 27 is marked oth		19a. Informant's Name/Relationship (Type, Print) Torrie Bailey / Daughter		ailing Address (Street a. Delaware A				
baltimore, Maryland permit. Page 1 and 2 should be filed Department of Health and Mental H Important: If item 27 is marked of any injury or other traumatic ever		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	cemetery, c	sposition (Name of crematory or other place 11e Cremato	ry 21, 2	2010 N	oc. Location - City or lewark, Del	
Dant permit. Depart Import any inj	ouce.	21. Signature of Funeral Service Licensee		22. Name and Address 127 South				aryland21901
		23a. Part 1. Enter the disease, or complications that caused t shock, or heart failure. List only one cause on each line.	he death. Do not e	enter the mode of dying	, such as cardiac o	r respiratory arrest	,	Approximate Interval Between
hysician		Immediate Cause (Final disease or condition	ic SI	-och	ond-	4200	3	Onset and Death
) Medica Examine	_	resulting in death) Due to (or as a of the control	consequence of):	- 1				1200
	ē	Sequentially list conditions, if any leading to it, it is little cause. Enter Underlying Cause (Disease or linjury	nominiquente offic					10dery
uted nd ransit	ami	cause. Enter Underlying Cause (Disease or linjury that initiated events c.						
rou cate be executed physician and the burial-transit	edical Examiner	resulting in death) Last Due to (or as a	consequence of):					
physic the b								
certific nding Jse as	Ž	IF FEMALE: 23b. Was decedent pregnapt 23c. If yes, outcome of					23d. Date of deli	ven
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			Month	Day Year
uires that n signed uld be del			_				cco use contribute to	
Tecords, The law requires ate has been sig	Completed by	Hoste Rend failure	لدغاس	1 chouse	ح :	performe	ed?/ death?	ompletion of educe of
an: The tifficate tor, pa	به ا	25. Was case referred to medical		26. Pla	ce of Death (Check	1 Yes 20	☑ No 1 ☐ Yes	2 🗆 No
VILAI hysician: his certific	To B	examiner? 1 🗌 Yes 2 No Hospital: 1 Inpatien	nt 2 🗆 ER/Outpar	tient 3 DOA Other	4 Nursing Ho	me 5 Residen	ce 6 Other (Speci	fy)
ing Pl	ate:	27. Manner of Death 28a. Date of injury (Month, Day, 'Month, Day, 'Mo		y work?	_	28d. Describe how	injury occurred	
VISION or Attendir frer death. irector: Af	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury	- At home farm	M 1 1	∕es 2 □ No	28f Location /Stree	et and Number or Rur	al Pouta Number
al or / s after I Dire		4 Homicide determined 28e. Place of Injury building, etc. (on dot, radioly, office	[City or Town, S		ar noute Number,
le Hospit n 24 hour e Funera	Medical	29a. Certifier Certifying Physician: To the best of m (Check 2 Medical Examiner: On the basis of exa only one) 3 Certifying Nurse Practioner: To the be	mination and/or inv	estigation, in my opinior	n, death occurred at	the time, date and	place, and due to the c	ause(s) and manner stated.
To th withii To th	-	29b. Signature and title of certifier		29c. License	number	290	d. Date signed (Month	
		Manite he	MID	. 7	0637	?30	2/16	110.
2		30. Name and address of person who completed cause of dea	th (Item 23a) (Type	e, Print)	PITAL	, EL	12 700	ND.
St Regist	ate trar	31. Date file And th. Dag Years 32. Registrary	s Signature	v				

	1 - State of Maryland / Departme Certifica	nt of Health and Mental F te of Death	Hygiene
Physician	1. Decedent's Name (First, Middle, Last)	2. Date of	Death Day Year 3. Time of Death
/Medical Examiner	4a. Facility Name (If not institution, give street and number) 4b. City	Town, or Location of Death	1ary 12, 2010 3:30 A M 4c. County of Death
		Easton r 1 Year If Under 24 Hrs. 8. Date of	Talbot
Funeral Director	102-22-5636 1XM 2□ F 81 Yrs. Months	Days Hours Min. 01/11	Birth Day, Year) 9. Birthplace (State or Foreign Country) New York
yland	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
he Mar 28a-f sl	MD Talbot Easton 10e. Street and Number 10f. Zi		1 X Yes 2 □ No
h with t		21601	10g. Citizen of What Country? USA
Iryland 21215-0036 thould be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural", or items 23 or 28a-f show matic event, the Medical Evamirer must be rofflind at To Be Completed by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent Ever in U.S. Armed Forces? 1	dent of Hispanic Origin? (Specify Yes or cify Cuban, Mexican, Puerto Rican, etc.)	No- 14. Race - American Indian, Black, White, etc. Specify: White
21215-0036 ed within 72 hours aft ygjene. rer than "natural", or t, It e Medical Everni Completed by F	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	ork done during most of working	16b. Kind of Business/Industry
d 21 filled will Hygier sht, III		18. Mother's Name (First, Midd	Law
© egge ⊒	Reginald Johnson	Dorothy Mal	oney
s 1 and 2 should of Health and Mer item 27 is marke other traumatic		o (Street and Number or Rural Route Number or Terrace, Easton	
Pages 1 and the first of He int: If item iny or other	20a. Method of Disposition 1 ☐ Burial 2 🏋 Cremation 3 ☐ Removal from State	other place)	20c. Location - City or Town, State
Baftim permit. Pag Department Important: any Injury conce.	4 □ Donation 5 □ Other (Specify) Chesapeake Cro	emation 02/15/2010	-
	Fellow 200 Sc	s, Helfenbein & Newath Harrison Stree	wnam Funeral Home, P.A. t, Easton, MD 21601 Approximate
Physician /Medical	23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the moshock, or heart failure. Hist only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	e of dying, such as cardiac or respiratory	y arrest, Approximate Interval Between Onset and Death
Examiner	Due to (or as a consequence of):	nel Falling	1 Weels
executed an and rial-transit Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	· Kal Dures	-Charac in
icate be executed physician and the burial-transit dical Examir	resulting in death) Last Due to (or as a 70 sequence of):	Pend	Pailure 10920
ertificat ling phy e as the	W IF FEMALE:		
nat the death certif d by the attending etached for use as Physician/Me	23b. Was decedent pregnant in the past 12 months? 1		23d. Date of delivery Month Day Year
be d	Part II. Other significant conditions contributing to death but not resulting in the underlying of		d tobacco use contribute to the cause of death? ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown
the taw requires the taw requires the taw been so page 2 should Completed		24a. Wa aui pei	topsy prior to completion of cause of death?
ician: certifica sector, p	25. Was case referred to medical examiner?	1 ☐ Yes 26. Place of Death (Check only	
Physical direction of the properties of the prop	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DO		esidence 6 Other (Specify)
ending eath. or: Afte the fune	1 ☑ Natural 5 □ Pending (Month, Day, Year) Injury 2 □ Accident Investigation	8c. Injury at Work? 28d. Describ 1 ☐ Yes 2 ☐ No	e now injury occurred
ital or Attending First after death. The control of the funers of the fu	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory building, etc. (Specify)	office 28f. Location City or T	(Street and Number or Rural Route Number, own, State)
o the Hospita ithin 24 hours o the Funeral ompletely fille		at the time, date and place, and due to the in my opinion, death occurred at the time	he cause(s) and manner as stated. ie, date and place, and due to the cause(s)
To the Within	29b. Signature and title of certifies	. License number	29d. Date signed (Month), Day, Year)
	30. Name and address of person who completed cause of death (Item 25a) (Type, Print)	WS (1)	7/10/10
RS 15	William H. Wood, Jr. 501 Dutchmans Lane,		
State Registrar		/	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Dennis G. Jenkins 2010 Feb Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) West VA 1 ₺ M 2 🗆 F 65 Months Days Hours (Month, Day, Director 1944 235-70-1148 6. Mar. Usual Residence of Decedent 28a-f shov 10a. State or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City. Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director 17 Yes 2 No MD Takoma Park Montgomery 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 1220 East West Highway #220 20910 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married ò Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Year or Dates Specify: Black 3 - Widowed 4 - Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working National Academy of life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha Security Officer Science Be other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Harry Jenkins Beverly McCann 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Norma Jenkins/ Wife 1220 East West Highway #220 Silver Spring, MD 20910 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 듄 Department of Important: If it any injury or o 1 The Burial 2 Cremation 3 Removal from State Suitland, MD 4 ☐ Donation 5 ☐ Other (Specify, 22 2010 shington National Eeb . Signature of Funeral Service 22. Name and Address of Facility John T. Rhines Funeral Home, LLC 3005 12th St. NE Washinton, DC 20017 23a. Part 1. Enter to disease, or complications that caused shock, or he in failure. List only one cause on each line. disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Interval Between Onset and Death Immediate Caus Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to (or as a consequence of RYARTERY DISEASE requires that the death certificate be executed use as the burlal-transi 0 RONA Due to (or as a consequence of): resulting in death) Last physician Be Completed by Physician/Medical KIDNEY DISEASE HRONIC P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No for Month Year Pregnam
Unknown Pregnant at time of death Day cate has been signed by the page 2 should be detached 1 ☐ Yes 2 ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ᡮ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 \(\text{\text{No}}\) this certificate 2 🗌 No 25. Was case referred to medica Division of Vital funeral director, 26. Place of Death (Check only one) 2 No Hospital: Other: မှ 1 🗌 Yes 1 🗷 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? Certificate: 28b. Time of I or Attending P after death. 28d. Describe how injury occurred 1 Accider 5 Pending Accident 1 Tes 2 No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Hospital Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

only one) 29b. Signature and title of certifie

31. Date filed (Month, Day

· Chandselle

FEB 1 9 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

m:D

Washington Adventist Hospital 7600 Carroll Ave. Takoma Park, MD 20912

MD 52 855

-16-2010

10-01258 Walter P. Johnson

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1- For State Certificate of Registrar	Death	Reg. N	lo.	0004
Physicia		Decedent's Name (First, Middle,Last)		Date of Death Month Da		3. Time of Death
Medical Exami		Walter Perry Johnson		February 11,	2010	1704 hrs
		, ,	c. City, Town, or Location of Death		4c. County of Death Wicomico	
		Peninsula Regional Medical Center	Salisbury	To Date of District	IM/DD/YYYY) 9. Birth	ralana (Phata na
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs Months Days Hours Min.	1	Foreign	1
Director	l	215-62-1670 1XM 2 F 55 Yrs.		12/02/19	54	^{ntry)} Maryland
Á		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Locatio	n			10d. Inside City Limits
Wo at	ļ					1 Yes 2 X No
yland yland	호	Maryland Wicomico Salisbury	10f. Zip Code	10g (Citizen of What Count	try?
e Mar or 28s	Director		Tot. Zip Gode	1.09.		,
72 hours after death with the Maryland n "natural", or items 23a or 28a-f show any al Examiner must be notified at once.		4392 Allen Road 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was	21801 Decedent of Hispanic Origin? (Sp	ecify Yes or No-	USA 14. Race - Americ	an Indian. Black.
ath w items	Funeral	1 Never Married 2 Married Armed Forces? If Ye	s, specify Cuban, Mexican, Puerto		White, etc.	
ter de		1 Yes 2 X No 3 Widowed 4 X Divorced If Yes, Give Year	Yes 2X No specify:		Specify: Blac	alz.
urs af tural	흘	or Dates:	s Usual Occupation (Give kind of v		b. Kind of Business/In	
72 ho	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) during mo	st of working life. DO NOT use reti	red)		
5-0036 led within 7/ Hygiene. other than the Medical	립	11th mechan	ic		American F	aving Co.
5-0 led w Hygie othe		17. Father's Name (First, Middle, Last)	18.Mother's Name	(First, Middle, Maid	en Surriame)	
21215-0036 uld be filed within 72 hours after Mental Hygiene. marked other than "natural", c event, the Medical Examiner	a	Edward Johnson	Wilhelm	ena Smith	1	7.0.1)
	잍		Address (Street and Number or F			
imore, MD 2 Pages 1 and 2 shoument of Health and I tant: Uitem 27 is roor or other traumatic	ı		riscilla Street - :		Maryland, 2 bc. Location - City or T	
Baltimore, permit. Pages I as Department of He Important: If ite		1 X Burial 2 Cremation 3 Removal from State crematory or other	er place)	0 /0010		1 1
timent trant:	IJ		s Mem. Pk 02/1		alisbury, M	
Baltimore permit. Pages l Department of I Important: If	1	1 1 3 01	LLEY MEMORIAL		TOTAL STATE OF	1801
Physician		23a, Part I. Enter the disease, or complications/that caused the geath. Do not enter the				Approximate Interval
Medical	3 1	failure. List only one cause on each line/				Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death) a. HYPERCENSIVE ACHIEFOS(Due to (or as a consequence of):	CACOLLIC CUITATOV	uocuiui c	120000	
	.	Sequentially list conditions, b				
	<u>.</u>	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause Circums a cinium that initiated				
	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
760, teate be executed physician and the burial - transit	జ	d				
be exician	Medical	X UNPENDED AMENDED 23a,27.perm.E g9	02 4/30/10 TT			
760, ficate be g physic the bur	Ž	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery Month Da	ay Year
Sox 687 leath certifu e attending for use as t	lä.	past 12 months?	al death — 3 ∐Ectopic pregna er <i>(Specify)</i>			,
Box 687 e death certifit the attending	Physician/	1 Yes 2 No 9 Unknown 9 Unknown				
P.O. B es that the de gned by the		Part II. Other significant conditions contributing to death but not resulting in the ur	nderlying cause given in Part I.		co use contribute to the	
s, P.C ires that signed l	ed by				No 3 Proba	
ords, w requir	ete			24a. Was an autopsy	prior to co	opsy findings available empletion of cause of
Reco The law icate has	Completed			performed		2 No
tal Rec ian: The certificate	Be	25 Was case referred to medical	26.Place of Death (Check	only one)		
Vital I hysician: this certifi	၀	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓ ER/Outpatient			idence 6 Other:	
n of Vi ding Physi After this	T:U	27. Manner of Death 1 X Natural 5 Panding 28a. Date of Injury (Month, Day, Year) 28b. Time of In		28d. Describe how	injury occurred	
ttend death.	atic	2 Accident Investigation	1 Yes 2 No			
Division of Vital Records, tall or Attending Physician: The law requirers after death. al Director: After this certificate has been sited in by the funeral director, page 2 should be	Certification:	3 Suicide 6 Could not be determined (Specify)	, factory, effice building, etc.	or Town, State		al Route Number, City
Division Hospital or Attenc 24 hours after death Funeral Director:		29a Certifier 1 Coult in Physician To the best of my knowledge death occurr	ad at the time, date and place, and	due to the cause(s)	and manner as state	d .
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation				
To To	Mec	and manner stated 29b. Signature and title of certifier	29c. License number	29	d. Date signed (Mon	th, Day, Year)
		6/11/11/11/	O.C.M.E.	F	ebruary 12, 2010	0
		30. Name and address of person who completed cause of death (Item 23a)				
		Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penr	Street, Baltimore, MD 21	201		
	tate	THOU OF EUTO AND TO A SECOND	i la			
Regis	trar				OUME	

State of Maryland / Department of Health and Mental Hygiene

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1-1	For Stata Registra
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Certificate of Death

Reg.	No
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			- negistrar					modio or	Doutin		Heg. No.		T
П	Physic	an	1. Decedent's Name (First, A EUGENE L. K	Aiddle, Last)						2. Date of De	RY 11,	Yeer	3. Time of Death 7:00 P M
	/Medi		4a. Facility Name (If not instit		reet and number	·)		4h City Town	or Location of Death			y of Death	7:00 P
	Examir	ner	CORSICA HILI						EVILLE		QUEEN		ı f e
	Funeral		5. Social Security Number	6. Sex	7. A	ge (in yrs. ia	st birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Bir	th		place (State or Foreign
В	Director		220-26-8031	1 🛣	M 2□ F	75	Yrs.	Months Days	Hours Min.	FEB. 28	1934	Com	YLAND
	P .		Usual Residence of Deceder										
	irytar ihow	_	10a. State 10b. Co	unty		10c. City,	, Town or Loc	cation				1	10d. Inside City Limits
	8a-1 8	cto		LBOT		EA	ASTON						1 X Yes 2 ☐ No
	or 2	Director	10e. Street and Number					10f. Zip Code			10g. Citizen of	What Coul	ntry?
	s 23e		302 N. WASHIN					2160			UNITED		
	item Per de	Funeral	11. Marital Status		 Was Deceden Armed Forces 1 X Yes 2 □ 	?	5. 13. V	Vas Decedent of Yes, specify Cut	Hispanic Origin? (S oan, Mexican, Puert	pecify Yes or No o Rican, etc.)		ce - Americ ack, White,	
36	I', or	by F	1 ☐ Never Married 2 ☐ 3 ☐ Widowed 4 🛣 Divo		If Yes, Give Year of Dates:		1	☐ Yes 2X No	Specify:		Speci	ty: WHI:	re .
Maryland 21215-0036	ges 1 and 2 should be filed within 72 hours after deeth with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-1 show or other traumatic event, the Medical Examinar must be notified at	ed	15. Dece	edent's Educa	ition		16a. Deced	ent's Usual Occu	pation		16b. Kind of I	Business/In	dustry
212	hin 7.	Completed	(Specify only h Elementary/Secondary (0-	1	College (1-4or	54)	(Give I life. C	kind of work done O NOT use retire	during most of wor ad)	king			
2	d witi	E	8	12)	College (1-40)	3+)	DELIV	VERYMAN			TRANS	PORTA	TION
פ	be filed ital Hygid of other event, it	Be	17. Father's Name (First, Mic	ddle, Last)					18. Mother's Nan	ne (First, Middle	, Maiden Suma	me)	
<u>a</u>	should b ind Menti marked umatice	2	ROBERT ROY K	TLMON					VIRGIN	IIA SHAR	P		
al	2 should be filed and Mental Hygi ie marked other aumatic event, I		19a. Informant's Name/Relat	tionship (Type	, Print)		19b. Mailin	g Address (Stree	tand Number or Ru	ral Route Numb	er, City or Town	, State, Zip	Code)
≥	fealth fealth om 27 ther tra		CHARLES KILM	ION/BRO	THER				INGTON ST	. EAST	ON, MD	21601	
9	of H of H if iter		20a. Method of Disposition 1 ■ Cremat	tion 3 ∏Rei	moval from State		ace of Dispos metery, crem	sition (Name of atory or other pla	асе)	Date	20c. Location	- City or To	own, State
altimore,	Pages ment of ant: If it ury or o		4 □ Donation 5 □ Othe		novai nom otati	OL	EVET C	EMETERY	FEB.	23,2010	ST.MIC	HAELS	, MD
Ball	permit. Pages 1 am Department of Heali Important: If item 2 any injury or other once.		21. Signature of Funeral Ser	vice Licensee			22. Tr	Name and Addr	ess of Facility	i e mpijn	AM ETING	DAT D	IOME, P.A.
_	<u>0</u> 0 = 0	1	Ratt	121			20	O POOLH	HARRISON	SI., KA	STON, M	D 216	01 F.A.
			 Part1. Enter the diseas shock, or heart failure. 	e, or complica List only one	tions that cause cause on each	d the death. line.				or respiratory a	rrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a	Kes	piral	029 7	FaiTure					Onset and Death
	/Medical Examiner		resulting in death)		Due to (of a	s a conseque	ence of):						weeks
и	Examine		Sequentially list conditions	b.		umor						4	weeks
	ed .	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	₹	Due to (or as	s a conseque	ence or):						
	s be executed sicien and burial-transit	хап	that initiated events resulting in death) Last	с.	Due to (or as	s a conseque	ance of):						
9	be e sicien buris					,							
89	he ye	응		d.									
9 x 68 / 60		an/Medical	IF FEMALE: 23b. Was decedent pregnan	, 230	. If yes, outcome	e of pregnan	су				23d D	ate of delive	any
ň	death death	clar	in the past 12 months?	•	1 ☐ Live birth 4 ☐ Pregnant a	2 Fetal of time of dea		Ectopic pregnand Other (specify) _	cy		1	onth	Day Year
j.	the cy by the achec	Physici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		9□ Unknown								
J	iaw requires thet the death es been signed by the etter 2 should be detached for t	by P	Part II. Other significant con			but not resul	ting in the un	derlying cause gr	ven in Part I.	23e. Did t	obacco use cor	ntribute to t	he cause of death?
Vital Records,	w require been sig should b	Pa	Acute 14	nal fa	ilure	- 11-1				10	Yes 2□No	3 Prot	pably 4 □Unknown
ပ္တ	s bee	Completed	Dementio	ı						24a. Was		Were auto	ppsy findings available
Ĕ	0 - 0	E	Matchelle a	a la Mh	alopath	1.					rmed3	death?	mpletion of cause of
<u>a</u>	ician: Th certificate rector, pag	0	25. Was case referred to me		Lupan	7			26. Place of Dea	1 ☐ Yes	2No	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	2 140
>	ysic lis ce direc	To B	examiner? 1 ☐ Yes 2 No	Hos	spital:	ent 2 E	R/Outpatient	3□ DOA Ot	_	ome 5□Resi		her (Specif	(v)
n 01	ng Pt ter th neral		27. Manner of Death Natural 5 □ Pe	a dina	28a. Date of Inj (Month, Da	ury 2	28b. Time of Injury	28c. Inju			how injury occu		
ğ	aath. or: Af	atlc	2 ☐ Accident inv	restigation	(, , , , ,	injury		Yes 2 □ No				
DIVISION	r Att	Certification:		termined	28e. Place of In	jury - At hon tc. (Specify)	ne, farm, stre	et, factory, office		28f. Location (City or To		ber or Rura	al Route Number,
ב	itel o												
	Hosp 4 hou Fune Fune	edical	(Check only 2 Med	ifying Physic ical Examina	r: On the basis of	of examination	ledge, death	occurred at the to	me, date and place opinion, death occu	, and due to the rred at the time,	cause(s) and m	anner as s	tated. o the cause(s)
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director,	Med	one) 29b. Signature and title of ce		and manner s	tated.							
	5 7 ¥ 7 8		South and the of the	14	4000	les 1.	Ø.	Zac. Licen	D754	33		1.12	·10
			20 None	////		7.10			10010			1	
			30. Name and address of per	lev. M	pieted cause of	Heath (Item)	coa) (Type, F	rint)	DISGO	actor	n. M	1) 2	1601
- 87	Sta	te	31. Date filed (Month Day)	940000	32. Repist	rar's Signatu	Ire &	1	-m, L	_~>/~/	-/ /-		
5	Registr		1 40	TOZU	IU Sen	was	p. 1	acked					

			For State	State of M	aryland		artment rtificate			and M	lental H		2.0	10	n e	554
			Registrar 1. Decedent's Name (First, Middle, Las	st)							2. Date of D	Reg. N	VO		3. Time o	of Death
	Physic		Dorothy	Faye			Karso	m			Month Februa		Day Ye 11. 20	ear	1:18	M
and the same	/Medi Exami		4a. Facility Name (If not institution, give)	_	4b. City, To		Location o	of Death	reprue	_	1c. County of		1:10	р
agent of			6737 Fairfax Road				Chevy	Ch	ase				Montgo	merv		
	Funeral		Social Security Number 6. S		ge (In yrs. la		If Under 1		If Under 2 Hours	24 Hrs. Min.	8. Date of B (Month, L				ce (State	or Foreign
	Director		084-14-82/1	□M 2 🔯 F	86	Yrs.	Wionara	Days	Tiours	IVIII I.	07/30/	1923	3	0001111	PA	
10	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City	Town or Lo	cation							100	i. Inside C	City Limits
1.0	f sho	ō	Maryland Montgom	10.77		vy Cha										s 2 No
7-61	the 1	rect	10e. Street and Number	iery	Cire	vy Ciia	10f. Zip C	Code			-	10a. (Citizen of Wha	t Country	v?	
	3a or	Ö	6737 Fairfax Road						2081	5			US			
	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Exertinar must be notified at	Funeral Director	11. Marital Status	12. Was Decedent		. 13.	Was Decede	nt of His			ecify Yes or N Rican, etc.)	0-	14. Race -	Americar		
9	or ite	Fu	1 ☐ Never Married 2 🛣 Married	Armed Forces 1 ☑ Yes 2 □						, Puerto	Rican, etc.)			White, etc		
21215-0036	ral",	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	WWI	I	1 □Yes 2	XI NO	Specify:				Specify:		Whit	е
5-(72 h	Completed	15. Decedent's Ed (Specify only highest gra	lucation de completed)		(Give	dent's Usual kind of work	done di	urina most	of worki	ng	16b.	Kind of Busin	ess/Indu	stry	
121	vithin ne. han	ם	Elementary/Secondary (0-12)	College (1-4or	5+)		DO NOT use	retired)	Ü							
7	iled v Hygie ther t		17. Father's Name (First, Middle, Last)	5+		Libra	arian		10 Motho	r'o Nomo	(First, Middle		Library	7		
anc	l be f ed ol	Be	Abraham Lincoln L								•	s, maiu	en Sumame)			
Maryland	thould ad Me mark mati	မှ	19a. Informant's Name/Relationship (7			10h Maili	na Address (Street a		y Ch		har Cit	y or Town, Sta	ata Zin C	'ada)	
<u>≅</u>	id 2 s Iffhar 27 is trau		Michael Karson, s				-						00 802		,00 0	
Je,	f Hear tem		20a. Method of Disposition	011	20b. Pla		sition (Name natory or oth				ate		Location - Cit		n, State	
DE	Pages nent of int; If its iry or o		1 ☐ Burial 2 ☑ Cremation 3 ☑ 4 ☐ Donation 5 ☐ Other (Specify						i	00/1	7/2010		-11- 01-	1.	17.5	
	# 문란증		21. Signature of Funeral Service Licen	<u></u>	NaL	22	Cremate 2. Name and	Address	s of Facility	V			alls Ch		ı, V1	rgini
m	Depa Impo any Ir		A CARDON		MO125	5 H	EDWARD	SAG	EL FU	UNER	AL DIR	ECTI	CON,INC Lle, Ma	; 	ınd	20852
			23a. Part 1. 1 ter the disease, or composition of the street street failure. List only	olications that cause	d the death.								ite inc		Approxima nterval Be	
-	Physician		Immediate Cause (Final disease or condition											l ö	Onset and	Death
	/Medical		resulting in death)	a. Cardiac Due to (or as			1									
	Examiner		Conversion to the conditions	b. AV Mode	Disf	unctio	n									
	p #	ner	Sequentially list conditions,	Dus to (or at	i it consulta	erice off:										
	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Examiner	d a y, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Atrial			n									
8760,	be ex ician cian	E E	resulting in death, East	Due to (or as	a conseque	ence ot):										
87	cate physi the k	dical		.d												
9 X	eath certific attending p for use as	Physician/Me	IF FEMALE:	23c. If yes, outcome	of pregnar)CV										
Вох	eath atter for u	cian	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2 Fetal	death 3[Ectopic pre						23d. Date o Month	,	ay	Year
o.	at the de by the tached	ıysı	1 □Yes 2 ⊠No 9 □ Unknown	9 ☐ Unknown			10ther (3pet	Jily)								
σ.	that ned b		Part II. Other significant conditions of	ontributing to death I	out not resul	ting in the u	nderlying cau	ıse give	n in Part I.		23e. Did	tobacc	o use contribu	ite to the	cause of	death?
rds	quires n sigr ald be	q p	Diabetes Mellitu	S							1 🗆	Yes	≱ [] No 3[☐ Probab	oly 4 🗆	Unknown
00	w require s been sig	Completed by	Hypertension								24a. Wa:	s an	24b. Wei	re autops	v findinas	available
Re	The lav	E I					-				auto peri	psy ormed?	prio dea	r to comp th?	oletion of	cause of
Vital Records,	ian; The intificate stor, pagi	BeC	25. Was case referred to medical						26 Place	of Death	1 ☐ Yes (Check only	one)	No	Yes 2	□No	
>	lis cel	P B	examiner? 1∏ Yes 2 ☐ No	Hospital: 1 ☐ Inpat	ent 2 🗆 E	R/Outpatier	nt 3 🗆 DOA	Otho	r·				6 □Other	(Snecify)		
Division of	or Attending Physician; after death. Director: After this certific in by the funeral director,		27. Manner of Death	28a. Date of Inj (Month, D	ury	28b. Time o		. Injury Work?			28d. Describe					
<u>o</u>	oftendir death. ctor: Al y the ful	Certification:	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation		.,, , , , , ,	ju.ry	М		es 2□N	No						
i <u>Şi</u>	l or Att after de Directe J in by t	ļį	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of in	jury - At hon tc. (Specify)	ne, farm, str	eet, factory, c	office		1	28f. Location City or To	(Street	and Number (or Rural F	Route Nur	nber,
0	intal of urs after and urs after and Discontinuous under the ursumment of												,			
Q.	Io the Hospital or vithin 24 hours after To the Funeral Directory of the Completely filled in the complete of	edical		ysician: To the best niner: On the basis and manners	of examinati											s)
1	Vithi To the	Me	29b. Signature and title of certifier				29c. l	License	number			29d. [Date signed (M	Month, Da	ay, Year)	
			mary Re	r sport	En					6165	5	Feb	ruary	12,	2010	
			30. Name and address of person who	completed cause of	death (Item	23a) (Type,	Print)									
			Mary Restifo, MD,				nue, N	W,	Washi	ingto	on, DC	20	016			
			31 Data files (Month Day Voor)	#2 Reniet	rar'a Cianati	ro.										

DHMH 17 Rev 1/2001

Registrar

Physicia /Medica Examine Funeral Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be confined at once. Baltimore, Maryland 21215-0036 Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State of Maryland				Mental Hyg	iene	0 00011
1 - State Registrar	Cei	rtificate of E	veatn		eg. No U	0 00544
1. Decedent's Name (First, Middle, Last)				2. Date of Deat	Day Year	3. Time of Death
IRVING KENS	LER	4h Oite Town on	Location of Do	FEB.	16, 2010 4c. County of De	
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or				GEORGE'S
ST. THOMAS MORE 5. Social Security Number 6. Sex 7. Age (In yrs. In	ast birthdav)	If Under 1 Year	TSVILLE If Under 24 H	rs. 8. Date of Birth	9. B	Irthplace (State or Foreign
365-20-8253 1X M 2□F 84	Yrs.	Months Days	Hours Mi	n. (Month, Day,		Country)
Usual Residence of Decedent		L		1001. 0,	1725 11	
10a. State 10b. County 10c. City	, Town or Lo	cation				10d. Inside City Limits
D.C. NONE	WA	SHINGTON				1X Yes 2 No
D.C. NONE 10e. Street and Number		10f. Zip Code		1	0g. Citizen of What (Country?
215 C ST. S.E. #303		200	03		U.S.A	.•
215 C ST. S.E. #303 11. Marital Status 1 □ Never Married 2 M Married 1 □ Never Married 2 M Married 1 □ Never Married 2 N Married	3. 13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? n, Mexican, Pue	(Specify Yes or No- erto Rican, etc.)	14. Race - Ar Black, Wh	nerican Indian, nite, etc.
If Yes, Give THITT		1 □Yes 2 X No	Specify:		Specify:	
□ 3 LJ Widowed 4 LJ Divorced Year or Dates: ₩₩±±					1	VHITE
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 2	(Give	dent's Usual Occupa kind of work done d DO NOT use retired	uring most of w		16b. Kind of Busines	ss/industry
Elementary/Secondary (0-12) College (1-4or 5+)	me.				TECAT DI	JBLICATIONS
		SALES_	18. Mother's N	lame (First, Middle, I	-	DELICATIONS
ERWIN A. KENSLER 19a. Informant's Name/Relationship (Type. Print)	_	na Address (Street		LOUISE Bural Boute Number	CAIG ; City or Town, State	Zin Code)
PRANEE KENSLER/WIFE 20a. Method of Disposition 20b. P	215	C ST.	S.E.		20c. Location - City	D.C. 20003 or Town, State
1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from State	emetery, crei	matory`or other place	i	.	•	
		CREMATOR Name and Addres		8-2010	_RIVERDALI	E, MD.
21. Signature of Funeral Service Licensee MOC		CHAMBERS	FUNERAL	HOME & C	REMATORIUM RDALE, MD	M,P.A. 20737
23a. Part 1. Enter the disease, or complications that aused the death shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequ	1501			liac or respiratory arr	72	Approximate Interval Between Onset and Death
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Could for sea consequence of the consequenc						
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Prevnonia Hyp	LAY	Léni101		24a. Was a autops perfor 1 □Yes	sy prior med? death	autopsy findings available to completion of cause of ?? 'es 2 🗆 No
25. Was case referred to medical				Death (Check only or	ne)	
	ER/Outpatie		4 Nursin	g Home 5 ☐ Resid	ence 6 Other (S	Specify)
27. Manner of Death 28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	Worl		28d. Describe h	ow injury occurred	
2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury - At he building, etc. (Specif.		- T 1	Yes 2□No	28f. Location (S City or Tow		Rural Route Number,
1	owiedge, dea ation and/or i	th occurred at the tinnvestigation, in my c	ne, date and pl pinion, death o	ace, and due to the occurred at the time, o	cause(s) and manne date and place, and	r as stated. due to the cause(s)
29b. Signature and title of certifier Hullinellinelline in	9	29c, Licens	number	2	29d. Date signed (Me	onth, Day, Year)
30. Name and address of person who completed cause of death (Iten 31. Date filed (Month, Day, Year) 32. Registrar's Signal	030		bory	Reltya.	the Hell	17,2010
FEB 18 2010	b. 4	ales				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

Sta Registr

4+1

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		State Registrar 1. Decedent's Name (First, Middle,	Last)		Certific	ate of Dea	ath	2. Date of De	Reg. No.	2011	0 0	554 e of Death
sician		Olive J.	Kellv					Month Februa:	Day	2010		05 A M
ledica amine		4a. Facility Name (if not institution,)	4b. (City, Town, or Loc	ation of Death	12002.00		ounty of Dea		05,11
		Glade Valley (Center			Walkersv	ille_			Frede	rick	
eral ctor		174-12-3417	6. Sex 1 ☐ M 2 🖾 F	Age (In yrs. last birtho	rs. If U		Under 24 Hrs. ours Min.	8. Date of Bir (Month, Da Sept 2	th 15, Yea <i>r)</i> 19	9. Bi 19 Pe	rthplace (Sta cuntry) nnsy1v	
notified at		Usual Residence of Decedent 10a. State 10b. County Maryland Fred 10e. Street and Number	erick	10c. City, Town o	Knox	ville			10a Citiza	en of What C	1 🗆	e City Limits Yes 2 🔀 N
st be		2015 Reed Road	4			21758					State	· C
ig .	ğ	11. Marital Status 1 ☐ Never Married 2 ☐ Marr 3 ☑ Widowed 4 ☐ Divorced	12. Was Deceden Armed Forces ied 1 Yes 2 If Yes, Give Year or Dates.	§? ☑ No	If Yes,	ecedent of Hispar specify Cuban, M es 2 🖾 No Sp	nic Origin? (Specifican, Puerto	ecify Yes or No- Rican, etc.)	14	. Race - Am Black, Whi	erican Indian	
t, the Medic	Completed		t's Education st grade completed) College (1-4 o	or 5+)	(Give kind or life. DO NO	Usual Occupation f work done during Tuse retired) Transcr	g most of work	ding		of Business	ernmen	t
natic even	To Be	17. Father's Name (First, Middle, L Stanley Taskey	<u> </u>				Kathr	ne (First, Middle yn Mats	20			
r traum		19a. Informant's Name/Relationsh Aileen Kelly –		19b. 20	Mailing Add	ress (Street and Nolf Cour	Number or Rur se Dri	al Route Numbe ve, Ger	er, City or To mantov	wn, State, Z m, Ma	ip Code) rylan d	208
any injury or other trai		20a. Method of Disposition 1	pecify)		Heav 22. Nam	(Name or or other place) en Cemet e and Address of Opossum	ery 2/	tauffer	Silv Funer	ver Sp	r Town, State ring, me ryland	Mary]
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लं 🏴	dical Examiner	shock, or heart failure. List of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last	a. Dury (ornable) b. Due to (or a		# 10 E	mode of dying, su	ch as gardiac V Tie Ochy		ulac	Des	Interval	mate Between nd Death
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** February Helen 18, 2010 Louella Lung 4:00 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Village At Robinwood Hagerstown Washington If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days 1 ☐ M 2 💢 F 86 Director 28 1923 216-22-8849 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f shot traumatic event, the Wedical Even for a ust be reallised at 28a-f show 1 ☐ Yes 2 No Director MD Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 18300 Tranquility Dr. Apt.233 Funeral 21742 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give A Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 Married altimore, Maryland 21215-0036 1 □Yes 2X No Specify 2 Specify. 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) tal Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Secretary/Treasurer Candy Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be h and Mental H 2 Herman David Barkdoll Katherine Alice Sheffler 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health Garland D. Lung/Husband 18300 Tranquility Dr., Apt. 233, Hagerstown, MD 21742 ce of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) f i Department o Important: If i any Injury or Once. ō 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Rest Haven Cemetery 2/22/2010 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown, MD 21742 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Rest Haven Funeral Chapel S. aren k 1601 Pennsylvania Ave., Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on the control of the control Immediate Cause (Final **Physician** Due to (or all consequence of): disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine law requires that the death certificate be executed signed by the attending physician and be detached for use as the burial-trans Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 No Month Year 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ≥ cate has been signated by page 2 should b 1 ☐ Yes 2 M No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe e Hospital or Attending Physician: The 124 hours after death.
24 hours after death.
9 Funeral Director: After this certificate ha letely filled in by the funeral director, page 2 No 1 ☐ Yes 2 📉 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 1 Yes 2 No 6 Other (Specify 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Death occurred at the time, date and place, and due to the cause(s) and manner as stated Death occurred at the time, date and place, and due to the cause(s) and manner as stated Death occurred at the time, date and place, and due to the cause(s) and manner as stated Death occurred at the time, date and place, and due to the cause(s) and manner as stated Death occurred at the time, date and place, and due to the cause(s) and manner as stated Death occurred at the time, date and place, and due to the cause(s) and manner as stated Death occurred at the time, date and place, and due to the cause(s) and manner as stated Death occurred at the time, date and place, and due to the cause(s) and manner as stated Death occurred at the time, date and place, and due to the cause(s) and date and place, and due to the cause(s) and date and place, and due to the cause(s) and date and place, and due to the cause(s) and date and place, and due to the cause(s) and date and place, and due to the cause(s) and date and place, and due to the cause(s) and date and place, and due to the cause(s) and date and place, and due to the cause(s) and date and place, and due to the cause(s) and date and place, and due to the cause(s) and date and place, and date and place, and due to the cause(s) and date a 29a. Certifier completely miner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 24 29d. Date signed (Month, Day, Year) 29b. Signatu 29c. License number

State Registrar

DHMH 17 Rev 1/2001

30. Name and address of pe

31. Date filed (Month

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ February Day 13. 5:46 р м 2010 Shu Chen Lung Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Holy Cross Hospital Silver Spring 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 □ M 2 🗗 F Days June 6, Year 923 China Director 492-80-3363 86 Yrs. Usual Residence of Decedent 23a or 28a-f shov 10a. State 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Montgomery Silver Spring 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 20902 USA Funeral 1135 University Blvd. West, #105 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. Armed Forces Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No within 72 hours after 1 ∐ Yes : If Yes, Give 1 ☐ Yes XX No Specify: 3 Widowed 4 Divorced Completed Asian Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home none Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) S. Unknown is marked o C.K. Lung ည permit. Page 1 and 2 should be Department of Health and Ments Important: If item 27 is marked 19a Informant's Name/Relationship (Type, Print) John Long/Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Zip Code) 9655 Baltimore Avenue, Laurel, MD 20723 injury or other 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date George Washington Cemetery Feb. 18 2010 18 4 Donation 5 Other (Specify) Adelphi, Maryland Prancis Collins Funeral Home 500 University Blvd. W., Silver 21. Signature of Funeral Service Licenses Inc. Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Atherosclerotic Heart and Vessel Disease Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Acute Myocardial Infarction Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Bradycardia that initiated events Due to (or as a consequence of): ŵ resulting in death) Last -burialattending physician for use as the buria Medical death certificate be IF FEMALE Physician/ 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month 5 Other (specify) Day Year Pregnant at time of death 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been sig Completed 24a. Was an 24b. Were autopsy findings available page 2 s prior to completion of cause of death? autopsy perform Yes 2 X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Yes 2 🙀 No ည 1 Inpatient 2 K ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 24 hours after death. 1 X Natural
2 Accident
3 Suicide injury work? 5 Pending vithin 24 hours after death. To the Funeral Director: Aisompleted filled in by the fu Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 XCertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Registrar

only one)

29b. Signature and title of certifie

31. Date filed (Month, Day,

30. Name and address of person who completed q

Lawrence Oufiero,

To the 1 vithin 2

Baltimore, Maryland 21215-0036

68760

Box

P.O.

Records,

Division of Vital

mr ise of death (Item 23a) (Type, Print)

2. Registrar's Signature

MD

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D19924

1500 Forest Glen Road, Silver Spring, MD 20910

29d. Date signed (Month, Day, Year)

February 16, 2010

29c. License number

			For	State of N	1arylan	•	rtment of H		/lental Hyg	iene			
	1 - State Certificate of Death								1	Reg. No. 2010 16548			
1. Decedent's Name (First, Middle, Last) Physician/ PEI ZHEN LU									2. Date of Deat Month FEB • 1	3, Day 20	Year	3. Time of Death 1:05 P M	
	Medic Examin		4a. Facility Name (if not institution, give				4b. City, Town, or	Location of Death		4c. Count		1 2 3 2	
			6806 BALTIMORE	AVE.		UNIVE	RSITY PA	RK	PR	INCE	GEORGES		
H	Funeral Director		5. Social Security Number 6. Security Number 1	7. A	ge (In yrs. Ia	st birthday) Yrs.	Months Days	If Under 24 Hrs, Hours Min.	8. Date of Birth (Month, Day, FEB 25	Year) . 1919	Coun	trv)	
	MC.		Usual Residence of Decedent	•									
	yland -f sho ed at	cto	10a. State 10b. County		10c. City	, Town or Loc			B. Date of Birth (Month, Day, Year) FEB • 25, 1919 9. Birthplace (State or Country) CHINA 10d. Inside Cit 1 X Yes 10g. Citizen of What Country? CHINA 17 (Specify Yes or No-Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Specify: ASIAN	0d. Inside City Limits			
	e Mar r 28a notifi	Sire	MD . MONTGOME 10e. Street and Number	RY			GAITHERS	BURG		1 Yes 2 No			
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	ems arm	Funeral Director	67 TIMBER ROCK	12. Was Decedent	Ever in U.S	. 13. V	208 Vas Decedent of His		ecify Yes or No-			an Indian	
36	ified within 72 hours after death with the Maryland ital Hygiene. od other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	þ	1 Never Married 2 Married	Armed Forces' 1 ☐ Yes 2 ☐ If Yes, Give		l .	Yes, specify Cubar ☐ Yes 2 🗓 No		Rican, etc.)	Bla	ck, White, e	etc.	
ë	ours a atural	eted	3 Widowed 4 Divorced 15. Decedent's Ed	Year or Dates.							AS.		
5	an "ng Medic	Completed	(Specify only highest gra	de completed)		(Give k	ent's Usual Occupa ind of work done do NOT use retired)		ing	16b. Kind of E	Business Inc	dustry	
Maryland 21215-0036	2 should be filed within 7: th and Mental Hygiene. 27 is marked other than traumatic event, the Me		Elementary/Seconday (0-12)	College (1-4 or	5+)		NURSE			NU	RSING		
nd	a filed tal Hy od oth event	To Be	17. Father's Name (First, Middle, Last)					18. Mother's Nam	e (First, Middle, N	laiden Surnam	ie)		
3	should be and Menta	۲	XI-JIU	LU									
ĭ	2 shou Ith and 27 is m		19a. Informant's Name/Relationship (Ty	, , ,			-					,	
ē,	1 and 2 of Healt item 2 other		MARIA CHANG/DAU 20a. Method of Disposition		20b. P	ace of Dispos	sition (Name of			20c. Location			
E E			1 ☐ Burial 2 🖾 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify			-	atory or other place CREMATO		-2010	RIV	ERDALI	E, MD.	
Baltimore,	permit, Page Department Important: I any injury or		21. Signature of Funeral Service Licens	nbush	2 моос								
H			23. Signature of Funeral Service Licensee M00091 23. Name and Address of Facility CHAMBERS FUNERAL HOME & CREMATORIUM, P.A. 5801 CLEVELAND AVE., RIVERDALE, MD. 20737 23a. Part 1. Enter the disease, or complications that caused the d, ath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between										
4	Physician/		Immediate Cause (Final disease or condition									Onset and Death	
	Medical Examiner		resulting in death)	Due to (or as	a onsequ	ence of):		10					
		ner	Sequentially list conditions, if any, leading to immediate	ence of):	ent	7.9		-	-				
	uted Id ansit	Examin	cause. Enter Underlying Cause (Disease or iinjury that initiated events										
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760	cate b physic the b	edical		d									
. Box 68	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcom 1 ☐ Live Birth 4 ☐ Pregnant 9 ☐ Unknown	2 Fetal	death 3	Ectopic pregnancy Other (specify)	/			ate of delive onth	ery Day Year	
S, P.O	res that the signed by the detact	d by Pł	Part II. Other significant conditions co	ntributing to death	but not resu	ılting in the uı	nderlying cause give	en in Part I.	23e. Did tob			e cause of death?	
ord	requi	lete							24a. Was ar		Were autor	osy findings available	
Vital Records,	The lav	Completed							autops perform	y ned?	prior to cor death? 1 \(\sum \) Yes	mpletion of cause of	
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<u> </u>	Physical this call direct	၉	1 ☐ Yes 2 ☒ No 27. Manne⊱ef Death	1 Inpa		ER/Outpatien 28b. Time of		4 Nursing Ho	ome 5 Reside	,		HOME	
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Division of	or Atter after dea Director in by the	Certificate:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Ir	ijury - At hor tc. (Specify)	me, farm, stre	et, factory, office		28f. Location (Str City or Town		er or Rural	Route Number,	
Ξ	spital cours a neral C	edical (29a. Certifier 1 Certifying Phys	ician: To the best of	of my knowle	edge death o	ccured at the time	date and place, an	id due to the caus	se(s) and mann	er as state	d	
	he Ho in 24 h he Fur pleted	Medi	(Check 2 Medical Examination only one) 3 Certifying Nurs	ner: On the basts of Practioner: To the	examination hear of my	and/or invest	gation, in my opinior eath occurred at the	n, death occurred a time, date and place	t the time, date and ce, and due to the	d place, and du cause(s) and m	e to the cau	use(s) and manner stated.	
_	Vith Volta		29b. Signature and title of certifier				29c. License	number	2	9d. Date signe			
			1 ///	H		5	1/00	5)00		1	-17-	-10	
			30. Name and odress of person who c	ompleted cause of	death (Item		PIKE #13A	. ROCKY	us Mo	2095	7		
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Jose Guillermo Tista Lemus

			1- For State Certificate of Death Reg. No.												
	Physician 1 Decedent's Name (First, Middle, Last) 2. Date of Death									V	3. Time of Death				
^_dic	al Exami		Jose Guillermo Tista Lemus									Month Day Year February 20, 2010			2344 hrs
			4a. Facility Name (if not institution	4	b. City, Town			Death							
			Dilston Road & Avenel Road					Silver Sp	oring			Montgomery			<u></u>
	Funeral		5. Social Security Number	6. Sex	7. Age (In y	yrs. last bir	thday)	If Under 1		If Under	_			TEOR	Birthplace (State or eign
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		ŀ	Usual Residence of Decedent		ı						1				
	any	ı	10a. State 10b. County		10c.	City, Town	or Location	n							10d. Inside City Limits
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	Aaryland 28a-f show 1 at once.	얁	10e. Street and Number			~ + + V	5	10f. Zip Co	de			1	0g. Citizen	of What C	ountry?
	uld be filed within 72 hours after death with the Maryland Mental Hygiene. marked other than "natural", or items 23a or 28a-f sho c event, the Medical Examiner must be notified at once.	Director	1811 Mount Pa	isgah In.	Apt.	32		209	03				Guat	temal.	a
	vith th s 23a e noti		11. Marital Status		cedent Ever		13. Was			anic Origi	n? (Spe	cify Yes or No			erican Indian, Black,
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ŏ	led within 72 hours after Hygiene. other than "natural", the Medical Examiner	Completed	17. Father's Name (First, Middle	, Last)						3.Mother's	Name (I	irst, Middle,			
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21;	d Me		19a. Informant's Name/Relations				Ū	•							ate, Zip Code)
M	l and 2 shou Health and I fitem 27 is n		Edwin Aroldo Ga	arcia/Frie											Md. 20903
رة 	Pages 1 and 2 should ment of Health and Me sant: If item 27 is ma or other traumatic ev		20a. Method of Disposition	2 🗆 🗆			of Disposit	ion (Name d er place)	f ceme	etery,		Date	20c. Loca	ition - City	or Town, State
Baltimore,	Pages ent of nt: If		1 Burial 2 Cremation 4 Donation 5 Other S		on State		•	Cemete	ery		03/0	3/10	G	uaten	nala
喜	permit. Page Department of Important: injury or other		21. Si ure Funeral Servi		MI				-	of Facility			hines	Fune	ral Home
ñ	Dep Inju		Checon	m. Ila								Washin			
Pl	nysician		23. Part I. Enter the disease, or	complications that	oused the d	eath. Do n									Approximate Interval
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87	tifica ing ph as the	M/M	23b. Was decedent pregnant in t past 12 months?		birth	programoy	2 Feta	al death	3	Ectopic	pregnano	су			Day Year
Box 68	eath certif attending for use as	Physiciar			nant at time		[er (Specify)							
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P.O.	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	by P	Part II. Other significant condi-	tions contributing t	o death but i	not resultin	ng in the ur	iderlying cau	ise giv	en in Par	t I.				to the cause of death?
٠,	sign sign											1 Yes	s 2 No	3P	robably 4 🗹 Unknown
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ဝင္က	ie law te has ge 2 s	Completed										perfo	rmed?	death	? Yes 2 No
ž	cian: The certificate ector, page										,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				
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Ξ	ospital or A hours after ineral Dire y filled in b	튑	3 Suicide 6 Could not be determined (Specify) roadway 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) Dilston Ro												
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			 Name and address of persor Theodore M. King, Jr. 		se of death i ant Medic		niner '	111 Penn	Stre	et Ralt	imore	MD 2120	1		
					egistrar's Sig	nature		entrantial)		, Dan		2120			
	Regis	tate	31. Date filed (Month, Dev, Year)	17 3 70 2 H L600		1. 4	Jack	1							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Carrie Marie Maurer State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Reg. No. 1. Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death 3. Time of Death Month Day February 17, 2010 ical Examiner 0155 hrs Carrie Marie Maurer 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Pulaski Highway & Melbourne Boulevard Elkton Cecil 5. Social Security Number **Funeral** 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Director Days 1 M 2 X F Country) MD 219-21-5996 29 Yrs June 18, 1980 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 Yes 2 No Ceci1 hours after death with the Maryland Conowingo Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 23a or 2 notified 130 West Red Hill Rd. 21918 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Ongin? (Specify Yes or No-14. Race - American Indian, Black 1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Yes 2 X No Divorced Yes, Give Year Pages I and 2 should be filed within 72 hours afte nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or other traumatte event, the Medical Examiner Specify: White 1 Yes 2 X No specify: ģ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 21215-0036 Roadside Service Assistant A.A.A. 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Kenneth Maurer Janet Ruffing 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, MD Kenneth Maurer/ father 130 West Red Hill Rd. Conowingo, MD 21918 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 2/22/2010 1 Burial 2 X Cremation 3 Removal from State permit. Page
Department of
Important:
injury or oth 4 Donation 5 Other Specify Rising Sun, MD R.T. Foard Funeral Home, P.A. 22 Name and Address of Facility
R.T. Foard Funeral Home, P.A.
111 S. Queen St. Rising Sun, MD 21911 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Approximate Interval failure. List only one cause on each line /Medical Between Onset and a Multiple Injuries Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examine cause. Enter Underlying Cause Due to (or as a consequence of): events resulting in death) Last signed by the attending physician and lee detached for use as the burial - transit The law requires that the death certificate be executed hysician/Medical UNPENDED AMENDED Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Fetal death past 12 months? Month Day Year Pregnant at time of death 5 1 Yes 2 No 9 ✓ Unknown Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Completed Division of Vital Records, certificate has been ector, page 2 should 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? ✔ Yes 2 1 V Yes the Hospital or Attending Physician; 25. Was case referred to medical 26.Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA After this Other Nursing Home 5 Residence 6 🗸 Other: Scene 1 Yes 2 No 27. Manner of Death 28a. Date of Injury 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? Certification: Feb 17, 2010 1 Natural Passenger auto auto collision 5 Pending hours after death To the Funeral Director: completely filled in by the 1 Yes 2 ✓ No 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be determined (Specify) Major Road / Highway Pulaski Highway & Melbourne Boulevard, Elkton, Md 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 24 cal 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medi 29b. Signature and title of certifier 29c. License number 29d Date signed (Month, Day, Year) O.C.M.E. February 17, 2010 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Ling Li, MD Assistant Medical Examiner 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar #17, FH, TCHD, pha 2/12/10 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death $\overset{\text{Day}}{2}\!0\underline{10}$ Feb. Physician/ 9 10:50 AM Elizabeth A. Markell Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b, City, Town, or Location of Death Examiner 32458 Covey's Landing Road Talbot Cordova If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Min. 1 M 2 X F Months Hours 3/10/1917 92 Marvland Director 213-20-6555 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 Yes 2 No MD Talbot Cordova 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 32458 Covey's Landing Road 21625 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White Specify: Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 11 0 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file Henry Wade Henry Wade Louisa Lowensen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health al Important: If item 27 is 32458 Covey's Landing Road, Cordova, MD Lois A. Markell, Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ■ Burial 2 □ Cremation 3 □ Removal from State or o Fairview Cemetery 2/18/2010 Cordova, Maryland Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home, P.A. CHOIL MERCERON 23a. Part 1. Enter the disease, or complications that caused the death. Do not emer the recent the result in the disease or storage or storage transfer the shock, or heart failure. List only one cause on each line. Interval Between Onset and Death DEMENTIA Physician/ ALZHEIMERS disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine cause. Enter Underlying Due to for as a consumence of the attending physician and hed for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Day Month Year Pregnant at time of death isigned by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ATRIAL FIBRILLATION 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of HYPERTENSION 24a. Was an autopsy performed? Yes 2 No has death? 1 Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical Certificate: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death completed filled in by the funeral 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Division of Vital Records, P.O. Box 68760 24 hours after death. Funeral Director: After within 2 To the I Registrar

31. Date filed (MFEB, Year) 2010 State

only one) 29b. Signature and title

> 1630 MAIN ST, SUITE 101 SUZANNE NIEMELA 32 Registrar's Signature

Leeule

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

D47311

29d. Date signed (Month, Day, Year) 02/09/10

CHESTER, MD

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 06553 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Month Februar 11:27PM William Joseph McVAY 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Washington County Hospital Hagerstown Washington 5. Social Security Number Year If Under 24 Hrs. 7. Age (In vrs. last birthday 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 ₹ M 2 □ F Min. (Month, Day, Feb. 24 Hours Virginia Director 218-34-9483 Usual Residence of Decedent 28a-f show 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No Maryland Washington Hagerstown ō 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 11 W. Baltimore Street #707 USA items 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🗓 No Black, White, etc. ō þ 1 Never Married 2 Married er than "natural", the Medical Exal If Yes, Give Year or Dates 1 ☐ Yes 2 🛛 No Specify: Completed 3 X Widowed 4 Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 0 Worker Construction marked other or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file 2 Leonard McVay Mamie Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lisa Stickley - Daughter 8409 Tusings Way, Boonsboro, Md. 21713 item 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a Department of H Important: If ite any injury or ot 20c. Location - City or Town, State cemetery, crematory or other place, 1 Durial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Hagerstown Crematory 2/23/10 Hagerstown, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Minnich Funeral Home E Vidas red 415 E. Wilson Blvd. Hagerstown, MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Retween Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical (of as a consequence of): Examiner mon Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or iinjury that initiated a continuous) co of: Invoure Osstrueline luy Disease) physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical use as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No for Pregnant at time of death Month Day Year 1 Yes 2 L 9 Unknown the g Unknown ed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ sign. be c 1 Nes 2 No 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy performed^a death? 2 🗌 No 1 Tyes Yes Physician: Be director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🖺 No 1 Tes ျှ 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death Certificate: al or Attending P s after death. I Director: After t 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending work? 2 Accident
3 Suicide
4 Homicide 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined 24 hours Hospital Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I only one 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signatu and title of certifie 29d. Date signed (Month, Day, Year)

State Registrar

13H-5

Maryland 21215-0036

Baltimore,

Box 68760

Records,

of Vital

Division

DHMH 17 Rev 7/2009

Name and address of person who completed cause of death (Item 23a) (Type, Print)

60 228

HLLL Avenue Haserstain

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1 Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ ^D**2**010 A1ma Marsden Feb. 13. 12:30A. M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Silver Spring Montgomery Woodside Center 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last hirthday) 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 TF JUTY 18 1937 578-50-9005 72 Washington, DC Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If time 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10h. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Prince George's Greenbelt 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20770 Funeral 23 Ridge Road, Unit P United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 X Never Married 2 Married Completed by 1 ☐ Yes 2 X No Specify: White 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+ Pre-School Teacher Education Be 18. Mother's Name (First, Middle, Maiden Surname) Catharine Glover 17. Father's Name (First, Middle, Last) Joseph B. Marsden ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Annette Marsden -niece 6003 Filbert Court Springfield, Virginia 22152 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Resurrection Cemetery 2/18/2010 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Clinton, Maryland 21. Signature of Funeral Service Licensee Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between nset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events and I-transit Exami Due to (or as a consequence of): resulting in death) Last physician a s the burial-Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by METASTATIC CANCER TIA, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of ATRIAL FIBRILLATION 24a Was an autopsy performed? death? 1 Yes 2 No Yes 2 LINO 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Hospital: ျ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: Af completed filled in by the fu 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 10 0057630 AMURADHA ARUN, MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

FEB 1

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

209

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Virginia Beryl McHugh 2010 February 8:00 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Lorien Nursing & Rehabilitation Ctr Mount Airy Carroll Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 🗆 M 2 🗶 F Days (Month, Day, Director 509-18-0439 Yrs. 88 Kansas Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🔀 No Montgomery North Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 15109 Winesap Drive 20878 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Completed 3 Nidowed 4 Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Give kind of work done during most of working d Mental Hygiene. marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Administrative Assistant Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Frank E. Winkler permit. Page 1 and 2 should be Department of Health and Men Important; If item 27 is marke any injury or other traumatic once. Roberta Bruner traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph M. McHugh / son 15109 Winesap Drive, North Potomac, MD 20878 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) February 2010 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, MD Gate of Heaven Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Francis J. Collins Funeral Home, Inc. 500 University Blvd.W., Silver MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph_sician/ disease or condition a End Stage Alzheimers Disease Years Medical resulting in death) Examiner Acute Upper Respiratory Infection Week Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence or): Exami attending physician and for use as the burial-transit Hypercholesteremia Years Due to (or as a consequence of) Physician/Medical Osteoporosis Years IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 🛣 No Month Day Year signed by the a 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed B12 deficiency, diverticulosis, peen 24b. Were autopsy findings available prior to completion of cause of death? Failure to thrive with dysphagia 24a. Was an sate has page 2 s autopsy performe After this certificate funeral director, pag 1 ☐ Yes 2 K No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 잍 Certificate:

the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 ithin 24 hours after death.

the Funeral Director: A pmpleted filled in by the fu

I LJ Yes 2 LALINO	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DCA	Assisted sidence 6 🖾 Other (Specify) Living									
27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not b	(Month, Day, Year) injury M		e how injury occurred								
4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, o building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 3 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. Signature and title of certifier) KOSUUKINO	icense number	29d. Date signed (Month, Day, Year) February 14, 2010								
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)											
Allen Reilly, M.D., 801 Toll House Ave. D-1, Frederick, MD 21701											
FEB 18 2010 3. Registrar's Signature											

State

Medical

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 06556 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month February Melissa 2010 Ellen Moore Medical 9:38 AM4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 5133 Cap Stine Road Frederick Frederick Social Security Number 7. Age (In yrs, last birthday) If Under Year If Under 24 Hrs. 8. Date of Birth (Month, Day, June 14 **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 🖾 F Months Days Hours Director 216-17-7425 Yrs. 974 <u>June</u> Maryland Usual Residence of Decedent show within 72 hours after death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🔀 No <u>Maryland</u> Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5133 Cap Stine Road 21703 United States 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces? Black, White, etc. 1 Never Married 2 X Married Ď. Maryland 21215-0036 If Yes, Give Year or Dates "natural", 1 ☐ Yes 2 🙀 No Specify: 3 Widowed 4 Divorced Completed White event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 1 and 2 should be filed within 72 f Health and Mental Hygiene. Item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) tient Service Coordinator American Radiology Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 은 Joseph Michael Geisinger Debra Ellen Glovd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Debra Geisinger/ Mother</u> 4404 New Design Road, Frederick, Maryland 21703 injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a
Department of H
Important: If ite
any injury or ott 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗌 Cremation 3 🗀 Removal from State Garden /17/2010 4 ☐ Donation 5 ☐ Other (Specify) Resthaven Memorial Frederick, Maryland. neral Servi 22. Name and Address of Facility tauffer Funeral Part 1. Enter the disease, or complications the shock, or heart fallure. List only one cause on caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Interval Between Onset and Death Immediate Cause (Final Ph_sician/ cencer disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence or): cause. Enter Underlying Cause (Disease or iinjury that initiated events the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit resulting in death) Last Due to (or as a consequence of): physician the burial Physician/Medical Box 68760 attending p for use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Day Year as been signed by the 2 should be detached 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 23e. Did tobacco use contribute to the cause of death? Completed 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Jas autopsy page perform death? After this certificate Yes 25. Was case referred to medical examiner? completed filled in by the funeral director. Be 26. Place of Death (Check only one) 1 Yes 2 XNo Hospital Other: 은 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending Accident Investigation 1 Yes 2 No 24 hours after deat Funeral Director: Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License numbe 29d. Date signed (Month, Day, Year) completed cause of death (Item 23a) (Type, Print) and address of person who Stree Frederick, MD 2/101

Registrar DHMH 17 Rev 7/2009

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32. Registrar's Signature

Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** Makuch February 23, 2010 \mathbf{A}^{M} 6:50 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Citizens Care and Rehabilitation Center Frederick Frederick Birthplace (State or Foreign Country) If Under 24 Hrs. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 🕱 F 171-10-1310 Director 4-15-1918 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla D. partment of Health and Mental Hygiene. Important; if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Medical Experiment has a cottled 2 gives. 1 XYes 2 No Funeral Director Frederick Frederick MD 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 1900 Rosemont Avenue USA 21703 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐Yes 2 ☐ If Yes, Give Year or Dates: 2 No 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 🖾 No Specify: ۾ 3 XWidowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Alexandra Gurecki Hnat Giduck 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9287 Black Pond Ln Delaplane, VA 20144 Linda J. Suter Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2-26-2010 Linwood, PA Lawncroft Cemetery 21. Signature of Juneral Ser 22. Name and Address of Facility Keeney & Basford P.A. F.H. M01176 106 East Church Street Frederick, MD 21701 23a. Part 1. Pirter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. STEMOSIS Immediale Cause (Final AORTIC **Physician** YEAR e or condition resulting in death) /Medical Due to (or as a consequence of): EART FAILURE MONTHS Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 No Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an perform rmed? 2 De No 1 □Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending To the mospins after death.

To the Funeral Director: Af 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Multiple Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature title of certifier 20062223 39 Name and address of person who completed cause of death (Item 23a) (Type, Print) FREDEZICK, MO 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Denve A. Mark

ORIGINAL

Registrar

Baltimore, Maryland 21215-0036

Box 68760.

P.O.

Records,

Division of Vital

DHMH 17 Rev 1/2001

		For State Registrar	State of Ma	aryland		artment of tificate of		nd Mental H	ygier Reg. 1	0010	1 065			
Di	,	1. Decedent's Name (First, Middle	, Last)					2. Date of D	eath		3. Time of D			
Physicia Medic		Leonard Leroy			M	yers, Sı		Februa	ry	Day Year 2:20				
Examir	ner	4a. Facility Name (if not institution, give street and number) Washington County Hospital				4b. City, Town, o		Death	4c. County of Death					
Funeral		5. Social Security Number	6. Sex 7. Age	e (In yrs. las	st birthday)	Hagers If Under 1 Year	If Under 24	Hrs. 8. Date of B	irth	Washing 9. Bi	g ton rthplace <i>(State or I</i>			
Director		215-18-1474 1 kg M 2 U F 86									ryland			
show	P	Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Loc	ation					10d. Inside City			
Department of Health and Mental Hygiene. Important If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	rect	MD Wash:	Ington	Ha	gersto	wn					1 X Yes 2			
Sa or 2	a D	10e. Street and Number				10f. Zip Code			10g.	Citizen of What C	ountry?			
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or ite	by F	1 ☐ Never Married 2 🔀 Mar	Armed Forces?	Armed Forces? 1 Yes 2 □ No If Yes, Give Year or Dates.		Yes, specify Cub	an, Mexican, P	uerto Rican, etc.))-	14. Race - Ame Black, Whit				
turar al Exa	Completed by	3 Widowed 4 Divorced	If Yes, Give Year or Dates.			☐ Yes 2 🛣 No	Specify:			Specify: W	hite			
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27 is r traur		19a. Informant's Name/Relationsh Naomi C. Myers/						r Rural Route Numb						
item othe		20a. Method of Disposition		20b. Pla	ace of Dispos	sition (Name of latory or other pla		е, <u>наgers</u> Date	21742 20c. Location - City or Town, State					
tant: I		1 🔊 Burial 2 🗀 Cremation 4 🗆 Donation 5 🗆 Other (S		- Tierrie fai il orii otato					Hagerstown, M					
Import any inj once.		21. Signature of Funeral Service L	icensee			Name and Addre				Funeral				
_ 10 0		23a. Part 1. Enter the disease, or	Suppose that assess	the death			-	a Ave., H		rstown,				
sician/		shock, or heart failure. List of Immediate Cause (Final	nly one cause on each line	·		Q12 1	y, such as car	diac or respiratory a	iresi,		Approximate Interval Betwee Onset and De			
edical		disease or condition resulting in death) a. Die to for is a consequence of):								IM				
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within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending p completed filled in by the funeral director, page 2 should be detached for use as	ldmi		<u> </u>					— 24a. Was		prior to	topsy findings ava completion of cau			
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uneral		27. Manner of Death 1 ∰Natural 5 ☐ Pendin	28a. Date of injur (Month, Day,		8b. Time of injury	28c. Injur work	y at	28d. Describe how injury occurred			,,			
y the f	Certificate:	2 ☐ Accident Investig 3 ☐ Suicide 6 ☐ Could r	dent Investigation M 1											
d in		4 Homicide determined determined determined bullding, etc. (Specify) 286. Place of Injury - At home, farm, street, factory, office bullding, etc. (Specify) 28f. Location (Street and Numb. City or Town, State)								ral Route Number,				
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mplet	Me	only one) 3 \square Certifying	Nurse Practioner: To the b	est of my k	nowledge, de	eath occurred at th	e time, date an	d place, and due to t	he cause	e(s) and manner as	stated.			
2 8		29b. Signature and title of certifier		29c. License number 29d. Date signed (Monte					. 1 1-					
		30. Name and address of person v	/ho completed cause of de	ath (Item 2	3a) (Tvpe. Pr	int)	10	2363	- 0	2 -01-	2710			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Luther Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death castal Hosp Cake palisbur COMICO Social Security Number Year If Under 24 Hrs 7. Age (In yrs. last birthday) If Under 1 **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 □ F (Month, Day, Year) Months Hours Min. .34-4246 Director 85 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Funeral Director 10d. Inside City Limits Wilcomico HELDRON 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? MARTIN 27/70 45P 71830 12. Was Decedent Ever in U.S. Armed Forces?

1. Yes 2 No If Yes, Give 11, Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Completed by 1 Never Married 2 Married Black, White, etc. 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced If Yes, Give Year or Dates. 43 -46 Specify: Black Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) D LABORER Be Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 KINNEY WRIGHT 19b. Mailing Address (Street and Number or Rural Route Number, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify Mary Jan 21. Signature of Funeral Service Lice 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ CARABROVAS CULAR disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner ESTROMY L Cequentiany list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Pregnant at time of death Month Year Yes 2 □ No ate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 Probably 4 ☐ Unknown 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of death? performed? Yes 2 No 1 🗌 Yes To Be 25. Was case referred to medical completed filled in by the funeral director, 26. Place of Death (Check only one) examiner? Hospital: Other: 1 Inpatient 2 ER/Outpatient 3 DOA hours after death. neral Director: After this 4 Nursing Home 5 Residence & Other (Specify) 27. Mariner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 5 - Pending injury 4 Natural Accident Suicide Investigation 6 Could not be 1 Tes 2 No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined within 24 hours and To the Funeral L Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and Atle of certifier 2005 8410

Registrar
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State

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32. Registrar's Signature

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Ruth Day 17 McCreath 1424PM 2010 February Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death HOPKINS BATVIEW MEDICAL ENTER BALTIMORE | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Y 1/21/1938) 5. Social Security Numbe 6. Sex 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 233-60-2800 Director WEST VIRGINIA Usual Residence of Decedent 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits WV BERKELEY MARTINSBURG 1XX Yes 2 No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 67 ARCH STREET 25401 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 72 hours after If Yes, Give Year or Dates 1 Yes 2 No Specify: BLACK Completed 3 Widowed 4 X Divorced Specify 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) CLARION HOTEL Elementary/Seconday (0-12) College (1-4 or 5+) DISHWASHER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F မ JAMES CALVIN REDMAN ROSIE LEE BROWN 19a. Informant's Name/Relationship (Type, Print)
CHARLES REDMAN/SON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 87 ARCH STREET, MARTINSBURG, WV 25401 permit. Page 1 and 2 st Department of Health a Important: If item 27 is 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ö 1 X Burial 2 Cremation 3 Removal from State PLEASANT VIEW MEM! PGOS MARTINSBURG, WV injury (4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility BROWN FUNERAL HOME, PO BOX 821, MARTINSBURG, WV 25402 Kobert 327 W. KING ST... Heids 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ BURN WOUND SESSIS Medical resulting in death) Examiner HTUOM 340 FORTY PERCENT TOTAL BODY SURFACE AREA HOT OIL BURN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) PROVED BY MEDICAL EXAMINED ng physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia the as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ o in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day Year Pregnant at time of death signed by t Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 performed? 1 Yes 2 No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? 2 🗌 No မ Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: Manner of Death 28b. Time of injury 28c. Injury at 28d. Describe how injury occurred EXTENSIVE HOT OIL BURNS AFTER POT SPILLED ON PATIENT ☐ Natural ☐ Accident 5 Pending January 17, 2010 1200 PM 1 Yes 2 □ No Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 235 Lewe Nr. RT. 43e South SHEPHEROSTOWN, WEST VIRGINIA 25143 determined KITCHEN AT CHRION HOTEL IN WEST VIRGINIA Medical 29a, Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certified 29d. Date signed (Month. Day, Year) RES- ()00 17. February 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MAYLAND BALTIMORY AVENUE PAPANDRY M.D 4940 EASTERN 21224 DOMINIC 31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 7/2009

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death January 29 Day 2010 9:08 р м W. Nelson 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Montgomery Rockville Potomac Valley Health & Wellness Center 8. Date of Birth (Month, Day, Sept. 13, 9. Birthplace (State or Foreign Country) Washington If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Days Min. Months Hours Y9906 103 537-20-9742 1 □ M 2 🗗 P Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 1 Tyes 2 No Maryland Rockville Montgomery 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code **USA** 20850 1235 Potomac Valley Road, #A211 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Hilga M. Puisku Otto A. Westerback 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 451 Hungerford Drive, #750, Rockville, MD 20850 19a. Informant's Name/Relationship (Type. Print) John Noble/Guardian 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Feb 2010 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Alexandria, Virginia Metropolitan Crematory 4 Donation 5 Other (Specify) 22. Name and Address of Facility Funeral Hone Inc. Francis J. Collins Funeral Hone Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Elimon (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 XNo Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐Yes 2 ☒No 24a. Was an autopsy 1 □Yes 2. No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 XNatural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No

/Medical Examiner Division of Vital Records, P.O. Box 68760

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29a, Certifier (Check only one)

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29b. Signature and title of certified

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?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Evanines must be notified at

filed within 72 hours after death with the Maryiand

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hyglene. Important: If tem 27 is marked other than "n any Injury or other team."

attending physician and the signed by the has certificate After this

Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after deat To the Funeral Director:

State

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12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

and manner stated

01 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Cular D. Rockville, NO 20850

Registrar DHMH 17 Rev 1/2001

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signatur

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Year)

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31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ George Wendell Phillips February 2010 1:17 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Anne Arundel Annapolis If Under 1 Year If Under 24 Hrs Months Days Hours Min. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 AM 2 □ F Months July 9, 1918 New York Director 91 009-01-4551 Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 XNo Maryland Oueen Anne's Stevensville 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 423 Craney Creek Road 21666 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces?

1 Xyes 2 No
If Yes, Give
Year or Dates. 1942–45 Black, White, etc. 1 Never Married 2 XMarried þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Je filed wn... ⁴at Hygiene. `ar than "r (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) should be filed with and Mental Hygien. 5+ Manager Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Robert Wendell Phillips other traumatic Alma Josephi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health a item 27 i Mary G. Phillips/wife 423 Craney Creek Road Stevensville, Maryland 21666 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 a Department of P Important: If ite any injury or of 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Journey Crematory 2/19/2010 Woodbine, Maryland 21. Signate of Funeral Service Licensee Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 M00957 23a. Part LEnter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ CALDIAC ALLHYTHMIA disease or condition Medical resulting in death) Due to (or as a consequence of). Examiner GNGESTIVE HAMIT Sequentially list conditions, hard, localing to in modificacuse. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence or; The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown 5 Other (specify) Month Day Year Pregnant at time of death signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, REMAL DISENSE 2 No 3 Probably 4 Unknown Completed 1 Yes BLADDER CANCER 24b. Were autopsy findings available prior to completion of cause of death? sate has page 2 s autopsy performed? Yes 2 No OF CHONIC DISENJE ANEMIA 2 🗌 No 1 🗌 Yes Yes Division of Vital or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: ည 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

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31. Date filed (Month, Day, Year)

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's Signature

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02-17-2010

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Ethel June Porter 18, February 2010 9:09 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 86 Winchester Court Port Deposit Cecil If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, June 3, 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min West Virginia 1 □ M 2 🕶 F 215-22-4656 86 June Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ?7 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Modical Examiner must be notified at Director Maryland Cecil 1 ☐ Yes 2/No Port Deposit 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 2 any injury or other traumatic event, the Mercal Examination 2000. 86 Winchester Court 21904 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates: 1 ☐ Yes 2 🔯 No Specify: 2 Specify: 3 X Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Twelve Years Homemaker Personal Residence 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Perry Jarrell Harriet Pettry 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 225 Principio Road, Port Deposit, MD Stephen L. Porter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Bel_Air_Memorial 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 02/24/10 Gardens
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Canden Bel Air, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Ŏ 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Due to (or a consequence of): **Physician** Cardiomyopatha 3months disease or condition resulting in death) /Medical Examiner Hyportension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physician: The law requires that the death certificate be executed the burial-transi and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Year Day 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by fibrillation 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2 ☑ No certificate | 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \sum Nursing Home 5 \text{Nasidence} 6 \subseteq Other (Specify) 1 ☐ Yes 2 🖾 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To After this 27. Manner of Death 28b. Time of 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred s after dea.. ral Director: After 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide To the Hospital within 24 hours a 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00028354 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 101 Colonial Way, Rising Sun, MD 21911 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Wellington Permansu : 35 AM 2010 Februa Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington County Hospital Washington County Hagerstown 7. Age (In yrs. last birthday) 72 yrs. 5. Social Security Numbe 443–34–8736 If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 1 M 2 □ F **Funeral** Days Min. March 227,1937 Director Oklanoma Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director PA Franklin Greencastle 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 775 Lohman Ave. U.S.A. 17225 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 1055 1 Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. American Specify: Indian 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Year or Dates. 1976 3 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Serviceman U.S. Army Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Clara Wahsaah Tooahimpah Simons Benjamin Yerpetah Permansu 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alesia A. Permansu-wife 775 Lohman Ave. Greencastle, PA 17225 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Smithsburg Crematory 2-22-2010 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg, Maryland 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licensee 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter U. disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause the each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) r as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or linjury Due to or as a consequence of): Exami physician and s the burial-transit requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year 1 Yes 2 9 Unknown signed by the a d be detached f Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Hospital or Attending Physician: The law has performed death? Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 🗌 Yes 2 🗷 No Other: ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide work? 1 ☐ Yes 2 ☐ No 5 Pending iours after death.

neral Director: Aft
filled in by the fur Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hou

To the Fune

completed fil 29c. License number 29d. Date signed (Month, Day, Year) Mesu B 2119/10 D62440

Box 68760

P.0.

Division of Vital

Registrar

Jaroslaw Kalka

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

251 E. Antietam St. Hagerstown, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ February 14, 2010 Barbara Rietveld 12:35 P M Η. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 5305 Falmouth Road Bethesda Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** ^{Year)} 1946 1 M 2 XF Months Days Hours Min. Aug 28, Director 545-70-3643 63 <u>New Jersev</u> Usual Residence of Decedent ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Montgomery Maryland 1 🗌 Yes 2 🔀 No Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5305 Falmouth Road 20816 United States within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Force Black, White, etc. 1 Never Married 2 Married 2 1 Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: 3 Divorced Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and 2 should be filed within 7. Health and Mental Hygiene. Interamerican Elementary/Seconday (0-12) College (1-4 or 5+) Development Bank 5+ <u>Publication Chief</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Philip Axelrod Dorothy Madar 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) J. Carlo Rietveld/husband 5305 Falmouth Road Bethesda, Maryland 20816 permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other 1 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Final Journey Crematory 2/17/2010 Woodbine, Maryland Signature of Funeral Service Lice 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD Thomas M00957 23a. Pard. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Small Physician/ Cell Cancer Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed the burial-transit Cause (Disease or iinjury that initiated events and resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death been signed by the should be detached g Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an this certificate has performed? Yes 2 No 2 🗌 No 1 Yes 25. Was case referred to medical funeral director. Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Hospital Other: 2 1 Inpatient 2 ER/Outpatient 3 I 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: s after death. 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Hospital 24 hours Funeral Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier The defining registration to the destrointy knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 29b. Signature and title of certifier D60372 MATI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 18 MD 21231 CRB2 Rm 553 1550 Orleans Christine

Registrar DHMH 17 Rev 7/2009

State

Box 68760

P.O.

Records,

Division of Vital

Registrar's Signature

Coescent.

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31. Date filed (Month

State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Da February Angelo Michael Ricciardelli 8:30 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 7101 Bay Front Drive #302 Annapolis Anne Arundel Social Security Number If Under 1 Year If Under 24 Hrs. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 1 Months Hours 074-03-6807 Director 101 4/28/1908 New York Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "--- any injury or other than "---10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Annapolis 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? Funeral 7101 Bay Front Drive #302 21403 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married Completed by XYes 2 NoWW II 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: White 3 Widowed 4 Divorced Korea Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Officer US Army Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pasquale Ricciardelli Judith Mongello 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8035 Georgetown Pike, Mclean, VA 22102 Claire Pettrone - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Arlington National Cem 4/27/2010 1 Burial 2 Cremation 3 Removal from State Arlington, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility JohnM. Taylor Funeral Home Myelin T. Klober 147 Duke of Gloucester St, Annapolis, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Dron Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to for as a consecution of cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed nding physician and use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 ase 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ atter in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death Day signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 🗌 Yes No 3 Probably 4 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy death? this certificate Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) ည 1 Yes 2 No Other: 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1- Natural 5 Pending 1 Yes 2 🗀 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor

To the Fune
completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0030741 2016 DW 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jeffrey Schmidlen 2 YIVA 844 Ritchie Highway Severna Park, Maryland 31. Date filed (Mo. gistrar's Signatur State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 20 2010 Year February William Vance Roney 11:22 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 13512 Donnybrook Dr. Hagerstown Washington County If Under 1Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, April 4, 6. Sex 1 X M 2 □ F 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 219-14-7850 Director 84 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Examinar mast be notified at 1 □Yes 2 No Maryland Washington County Director Hagerstown 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 13512 Donnybrook Dr. 21742 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify Specify: White þ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Director of Marketing Bank 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental He Important: If item 27 is marked oth any Injury or other traumatic event Be Ray Victor Roney Catherine Schnebley Vance Roney 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty J. Roney-wife 13512 Donnybrook Dr. Hagerstown, MD 21742 Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Rose Hill Cemetery 2-25-2010 Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licenses 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** alignance /Medical Due to (or as a lonse luence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician; The law requires that the death certificate be executed and Due to (or as a consequence of) Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? Month 4 ☐ Pregnant at time of death 5 Other (specify) P.0. □Yes 2□No ed by the a 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t page 2 s autopsy performed? certificate Division of Vital Valvular 0 1 □Yes 2 No 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Höspital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? After i 28d. Describe how injury occurred 1 Natural 5 Pending investigation n 24 hours after death.

See Funeral Director: A pletely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier To the Hosp within 24 hou To the Funel completely fil (Check only one) and manner stated 00265 2010

00H4+1

State Registrar

I. Date filed (Month Pay Year)

32. Rigistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

back

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Jeannette Kaylor Byler Rutledge 133 м Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Washing ton HOSPAZ Haperstown 20 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral 1 □ M 2 🛛 F April Day Year 1913 213-16-1714 96 MaryTand Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Washington County Williamsport 1 🗆 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 16505 Virginia Ave. 21795 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married ò If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Guidance Counselor Board of Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Harry Wesley Kaylor Lula M. Eakle Kaylor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jane B. Stroot-daughter 4502 Puller Dr. Kensington, MD 20895 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Rest Haven Cemetery 2-20-2010 |Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licensee 1331 Eastern Blvd. North Hagerstown, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final onecotive Physician/ disease or condition Medical resulting in death) Due to (or as a correquence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burlar-fransit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

December at time of death 5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Ø Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 X N 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🖾 Natural injury work?
1 Yes 2 No 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 00068976 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Washington Beyene Grum 31. Date filed (Month, Day, Year) 32. gistrar's Signature Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar MEND#20bperrFH, 2/24/10, BMW, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Februar Mary E. Ream Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Doctor's Community Hospital Lanham Prince George's . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Hours Oct.4.1917 Director 194-01-2808 92 Pennsylvania Usual Residence of Decedent "natural", or items 23a or 28a-f shov idical Examiner must be notified at 10b. County 10c. City. Town or Location 10d. Inside City Limits Director Maryland Prince George's Bowie 1 X Yes 2 □ No 10f. Zip Code 10g, Citizen of What Country? Funeral 3850 Enfield Chase Court, #104 20716 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc 1 Never Married 2 Married Completed by 1 Yes 2 No Specify: White If Yes, Give Year or Dates 3 XWidowed 4 ☐ Divorced Specify: permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Secretary Montgomery College Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ John W. Shearer Jeannette Morgan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1301 Persimmon Tree Court Crofton, MD 21114 Janet R. Radman -daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State $2-19^{\text{Data}}_{-2010}$ cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Richland Cemetery 4 Donation 5 Other (Specific 2/18/2010 Johnstown, Pennsylvania Signature of Funeral S Bonald V: Borgwardt Funeral Home, P.A. 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying attending physician and for use as the burial-transit Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day Year signed by the a 1 ☐ Yes 2 ■ 9 ☐ Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy this certificate Yes 2 funeral director. 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner 1 Yes 2 No Hospital: Other: 1 Inpatient 2 ER/Outpatient 3 DOA မ 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d Describe how injury occurred After (Month, Pay, Year) 930 Natural Accident 5 Pending death. 1 🔲 Yes 2 400 Investigation tall 24 hours after deatle Funeral Director: 28f. Location (Street and Number or Rural Route Number, 3650 Chip et a Chase Covi 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide filled in by determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. So Wiley Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier within 24 ho

To the Fune

completed f (Check 3 only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 9 29d, Date signed (Month, Dav. Year) 12 m DD 60611 WC 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Asfaw 8118 Good Danuel MD. Lanham, MD. Lucic Rd., 31. Date filed (Month, Day, Year) State FEB 17 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician Month Year 1150 AM Rainer Louis 2010 0 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Worlester Atlantic General Hospital Berlin If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 4/11/1929 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Min. Months 1 🛛 M 2 🗆 F Days Hours 80 117-20-5960 Director Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f show event, the Medical Exeminer must be notified at Director 1 ☑ Yes 2 ☐ No MD Worcester Ocean City 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code items 23a or 406 Bering Rd. 21842 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 X Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2X Married 2 No o, 3altimore, Maryland 21215-0036 1 ☐Yes 2 🛛 No Specify Specify: white 3 Widowed 4 Divorced 'natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Owner/Operator International Consulting Is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Louis L. Rainey, Sr. Matilda Vegara 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Geraldine E. Rainey / wife 406 Bering Rd., Ocean City, MD 21842 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🗡 Cremation 3 ☐ Removal from State Cape Henlopen Crem. 2/17/2010 Frankford, DE 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Burbage Funeral Home 21. Signature of Funeral Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 108 William St., Berlin, MD 21811 Approximate Interval Between Onset and Death Immediate Cause (Final End **Physician** 5+a disease or condition resulting in death) /Medical Due to (or as a consequence M Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) P.O. Box 68760. Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 □Yes 2 □No Month Day Year 5 ☐ Other (specify) hed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 2 1 ☐ Yes > No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an 1 ☐ Yes 2 XNo of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No No Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To Hospital or Attending Pl 24 hours after death. Funeral Director: After the 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the I within 2 To the I 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 00062130 161 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BA 15+1 Henlthway Dr. Berlin, MD 9733 Anvia, M.D. 21811 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

FEB 18 2010

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registral Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2010^{Ye ar} Roller February 10, **Physician** Clyde Leroy 8:50 p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Laurel Regional Hospital Laurel P.G. 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 4, 1924 9. Birthplace (State or Foreign Country) Pennsylvania 6. Sex 7. Age (In yrs. last birthday) **Funeral** Min. Months Days 1X M 2 □ F 206-16-4527 85 Yrs. May 4, Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at Director 1 ☐Yes 217 No Maryland Mon topmery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a or 3118 Gracefield Road, Apt. 420 Funeral 20904 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White If Yes, Give Year or Dates; unknown ģ 1 ☐ Yes 2X No Specify: 3 Widowed 4 Divorced natural Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: if item 27 is marked other that any injury or other traumatic event, ITML ORIGE. Television Engineer WITT.A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clyde L. Roller Alene Burchill 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard L. Roller/Son 2703 Leaf Drop Court, #3, Silver Spring, MD 20906 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 35 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 3X Removal from State Odd Fellows Cemetery 2010 Laurel, Delaware 21. Signature of Fundiral Service License 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Parvi. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Small Bowel Obstruction disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): burial-transit Due to (or as a consequence of): The law requires that the death certificate be exe P.O. Box 68760 Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) ed by the a 9 Unknown cate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ Suspected Ischemic Colitis, Paroxysmal Atrial Fibrillation 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖺 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe certificate Vital 1 □ Yes 2 No 2 □No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Division of After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. investigation e Hospital or Attendi 24 hours after death. e Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 1 Ccrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only To the l 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D24035 February 11, 2010 10

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

FEB 18 2010

23A I+II Oh

Name and address of person who completed cause of death (Item 23a) (Type, Print)
 Eugenio S. Machado, MD 3110 Gracefield Road, Silver Spring, MD 20904

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible? State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ 3. Time of Death Month Day February 24, 2010 dical Examiner 0332 hrs Eusebia Rivas 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year | If Under 24Hrs. | 8. Date of Birth(MM/DD/YYYY) | 9. Birthplace (State or Foreign | E.L. 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Director 219-31-9115 Country) Salvador Oct. 29, 1 M 2 X F 45 1964 Yrs Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 X No 28a-f show MD Silver Spring other than "natural", or items 23a or 28a-f shothe Medical Examiner must be notified at once. Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 12510 Barbara Road 20906 ö El Salvador Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, ges I and 2 should be filed within 72 hours after death v of Health and Mental Hygiene.

If item 27 is marked other them "... Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. 1 Never Married 2 X Married 2 X No 1 Yes 3 Widowed 4 Divorced If Yes, Give Year 1 X Yes 2 No specify: El Salvadoran Specify: ģ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Com 17. Father's Name (First, Middle, Last) 18 Mother's Name (First_Middle_Maiden Surname) traumatic event, Be Alicia Garcia Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wilfredo Garcia / Son 12510 Barbara Road, Silver Spring, MD 20906 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date or other crematory or other place) 1 X Burial 2 Cremation 3 Removal from State San Vicente, Berlin Cemetery important: 4 Donation 5 Other Specify: El Salvador 21 Signature of F n al Se ic icensee 22. Name and Address of Facility DeVol Funeral Home, 2222 Washington . DC Wisconsin Avenue, M 00689 if If Entir the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician fure. List only one cause on each line Between Onset and /Medical Death Acute alcohol intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examine if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit ician/Medical ding physician a AMENDED 23a,27,28a-f,permE, g901 3/16/10 TT X UNPENDED Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown Unknown Part II. Other significant conditions 23e. Did tobacco use contribute to the cause of death? teate has been signed by page 2 should be detached contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 V Unknown Completed this certificate has been 24a Was an 24b Were autopsy findings available prior to completion of cause of autopsy performed? death? ✓ Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Hospital or Attending Physician: Be Hospital: 1 Inpatient 2 🗹 ER/Outpatient 3 🔲 DOA Other Nursing Home 5 Residence 6 Other 1 🗸 Yes 28a. Date of Injury (Month, Day, Year) After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 1 Yes 2 X No 5 Pending Director: d in by the f subject ingested alcohol hours after death. Fd 0240 hrs Fd 2/24/10 2 X Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City RockWille, 46 MD College Pkwy 6 Could not be Suicide other within 24 hours a To the Funeral I 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated cal 2 🗸 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar DHMH 17 Rev 1/2001

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State

30 Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

82 Registrar's Signature

Russell Alexander MD.

O.C.M.E

111 Penn Street, Baltimore, MD 21201

OCME

February 25, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Elizabeth Roeller 10:12 AM February 2010 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, Examiner Laurel Kegional Hospital Laurel Georges If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug. 9, 1923 Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1 □ M 2 🙀 F Yrs 218-14-0959 86 Maryland **Director** Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-f shot any injury or other traumatic event, It is Medical Exact in a first must be notified at 1 ☐ Yes 2 No Prince George's Maryland Laurel 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 11202 Poplar Grove Court 20708 United States Funeral Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐Yes 2X No White Specify: ð 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Elizabeth Johnson William George Vogel 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Debra A. Secreast -daughter 11202 Poplar Grove Court Laurel, Maryland 20708 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metropolitan Crematory 2/24/2010 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each liqe. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): came reporting + VRE. Examiner Sis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): physician and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical ast IF FEMALE: nse 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy ģ in the past 12 months? 1 □Yes 2 No Month Year Day n signed by the a Id be detached fo 5 Other (specify) P.O. I 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, \$ 1 Yes 2 No 3 Probably 4 Unknown To the Hospital or Autonomition 24 hours after death.

To the Funeral Director: After this certificate has been signed the Funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy 1 ☐ Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မှ 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day, Year) Division 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar

DHMH 17 Rev 1/2001

Lourel Regional Hospital

7300 Van Dusen Rd.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mohamed Tourky, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February Frank Schroder 2010 5:00 P^{M} James Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Rockville National Lutheran Home Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** ug 20, 1927 1 ★ M 2 □ F Months Days Hours Min. Yrs Director 394-20-6931 Aug Michigan 82 Usual Residence of Decedent or 28a-f show notified at 10b. County 10a, State 10c, City, Town or Location 10d. Inside City Limits Director Maryland Montgomery Rockville 1 Yes 2 XNo 6 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? er than "natural", or items 23a or the Medical Examiner must be 9701 Veirs Drive 20850 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates. 1945–46 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. ò 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: White 3 Widowed 4 Divorced Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life, DO NOT use retired) during most of working should be filed within 72 and Mental Hygiene.
7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) 4 Salesman Greeting Cards Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic. Swen Schroder Anna Grotenmeyer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alexandria, VA 22314 Rose Ann Schroder/wife 1202 S. Washington St, #116 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2x Cremation 3 Removal from State Final Journey Crematory 2/18/2010 4 ☐ Donation 5 ☐ Other (Specify) Woodbine, Maryland Signature of Funeral Service Lice Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 M00957 23a. Park . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or a spiratory arrest, shock, or heart failure. List only one cause seach line onset and beath Immediate Cause (Final Physician/ disease or condition resulting in death)) Medical Dualo (or as a consequence of) Examiner eun Sequentially list conditions if any, leading to immediate cause. Enter Unidentifying Cause (Disease or iinjury ue to (or as a consequence of) Examir physician and the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 attending p 23c, If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Dav Year 1 Yes 2 L g Unknown been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy page perform 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical **Division of Vital** Hospital or Attending Physician: funeral director, Be 26. Place of Death (Cleck only one) examiner? Hospital: Other: မ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending after death. 2 Accident
3 Suicide
4 Homicide 1 Yes 2 🗌 No Investigation filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 24 hours Funeral Medical 29a. Certifier 🖊 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. сопріете Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 1 within 2 To the 1 ny on Certifying Nurse Frantianer: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated and title of certifier 29b. Signatur telorvers 11,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 541 Charle W. Karesh 9701 Veirs Drive Rockville, Maryland 20850 31. Date filed (Month, Day, Year) 32. egistrar's Signatur State

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Registrar

P.O.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ FEBRUARY 8 MARGARET F. SHORES 2010 6:20 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death TRAPPE TALBOT 30790 BRUCEVILLE ROAD Social Security Number 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours 1 🗆 M 2 🗶 F 12/16/1931 MARYLAND Director 78 220-26-3122 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland Director r 28a-f sh notified a 1 Yes 2 X No TALBOT TRAPPE MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö items 23a or ner must be n Funeral 21673 USA 30790 BRUCEVILLE ROAD Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14 Race - American Indian. n "natural", or item ledical Examiner r Black, White, etc. Completed by 1 Never Married 2 Married ☐ Yes 2 🗶 No Maryland 21215-0036 1 ☐ Yes 2 X No Specify: WHITE If Yes, Give 3 X Widowed 4 Divorced Year or Dates. the Medical 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 11 0 HOMEMAKER OWN_HOME Page 1 and 2 should be filed wit ment of Health and Mental Hygie ant: If item 27 is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ 27 is marked or traumatic e HARRY M. SAUNDERS FRANCES COLEMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) THERESA S. DULIN/DAUGHTER 30540 DEEP BRANCH ROAD, TRAPPE, MD Department of Health Important: If item 27 any injury or other tr Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place LANDING NECK CEMETERY 2/19/2010 TRAPPE, MARYLAND 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. MERCERON GHOL 200 SOUTH HARRISON STREET, EASTON, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betwee Inset and Death Immediate Cause (Final LUNG CANCER Physician/ YEAR disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of, The law requires that the death certificate be executed Cause (Disease or linjury that initiated events and burial-tran Due to (or as a consequence of) resulting in death) Last physician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy perform 1 Yes 2 No Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medica funeral director, 26. Place of Death (Check only one) Certificate: To Be Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28c. Injury at 28a. Date of injury (Month, Day, Year) 28b. Time of Natural Accident 5 Pending ours after death.

neral Director: Affilled in by the full 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. сопретер (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature

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DHMH 17 Rev 7/2009

State

Registrar

strar's Signature

8221 TEAL DRIVE, STE. 301, EASTON, MD

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 2010

DAVID H. SMITH

31. Date filed (Month)

D39877

21601

09/2010

10-01556 Victor Eduardo Saniel

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Victor Eduardo Saniel February 20, 2010 2312 hrs Madical Examiner 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Charles Waldorf 3325 Leonardtown Road If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number Age (In yrs. last birthday) If Under 1 Year **Funeral** Feb.28,1965 Min Months Davs Hours 44 Director птклоwn **5–58–9564** 1 X M Usual Residence of Decedent 10d. Inside City Limits any 10a State 10b County 10c. City, Town or Location Charles MD Waldorf 1 Yes 2 No 28a-f show If item 27 is marked other than "natural", or items 23a or 28a-f sho ner traumatic event, the Medical Examiner must be notified at once, death with the Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 5104 Mahi-Mahi Place 20603 US Funeral 11. Marital Status 12, Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. 1 Never Married 2 X Married Yes 24 X No Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after of Bealth and Mental Hygiene. If Yes, Give Year or Dates: 3 Widowed 1 Yes 2 No specify: Puerto Rican Hispanic ð 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Private 12th Laborer 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Elba Edith Maldonado Victor Jose Saniel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5104 Mahi-Mahi Place Waldorf, MD 20603 Elba Orellana /Mother 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place 1 Burial 2X Cremation 3 Removal from State 2-26-10 Riverdale, MD tant: Riverdale Crematory Donation 5 Other Specify 22. Name and Address of Facility BRISCOE-TONIC FUNERAL HOME 21. Signature of Funeral Service Licenses 10 C Old Washington Rd Waldorf Part I. Enter the disease, or complication failure. List only one cause on each line. Approximate Interval disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and /Medica Death Heroin intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Due to (or as a consequence of): if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and Physician/Medical AMENDED 23a,27,28a-f,permE, X UNPENDED attending physician or use as the burial g901 3/11/10 TT Hospital or Attending Physician: The law requires that the death certificate be Records, P.O. Box 68760. 23d Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 1 Live birth Ectopic pregnancy Dav Yea Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 V Unknown Completed this certificate has been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of performed? death? ✓ Yes 2 No 1 🗸 Yes 2 No 26 Place of Death (Check only one) 25. Was case referred to medical Division of Vital Other₄ Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 ✔ Other: Scene 1 🗸 Yes 2 No 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b Time of Injury After 27 Manner of Death Certification: Natural 1 Yes 2 X No d Director; / Pending death. Fd 2/20/10 Fd 11:!5 pm 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3325 Leonartown RD Waldorf, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc 6 X Could not be Suicide storage unit determined (Specify) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the 29c. License number 29d, Date signed (Month, Day, Year) 29b. Signature and title of certifier O.C.M.E. February 21, 2010 30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Pay Year) 32 Registrar's Signatur State

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State of Maryland / Department of Health and Mental Hygiene
State Amend Items 23aPt1.27 per me e901.03/04/2010dhb
Registrar Amend 21per FH, G901, 03/16/10dhb Certificate of Death

Reg. No. 2010 Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 085 . Medical 4a. Facility Name (if not institution Examiner City, Town, or Location of Death 4c. County of Death umn 12GAN Funeral 8. Date of Birth 9. Birthplace State or Foreign 1 M 2 🗆 Months Hours Min. (Month, Day, Country) Director permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 🗆 No 10f. Zip Code 10g. Citizen of What Country? Funeral 6 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sur, မ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and No 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 ☐ Other (Specify) James F. Scarpelli 2 per DVR 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, pproximate Interval Between shock, or heart failure. List only one cause on each lir Immediate Cause (Final Physician disease or condition resulting in death) Medical Examine Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury the bunal-transit and that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician a be detached for use as the burial Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be 22/10 Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 0)00 d Completed 1 Yes 2 No 3 Probably 4 Wunknown peen Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has autopsy performed?

Yes 2 No death? 1 Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 🗆 No Other: မ 1 Dinpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After injury Natural 2 Accident 5 Pending 2/13/10 Investigation 6 Could not be 300 1 Tes PATIENT 3 Suicide 4 Homicide Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined MESIDEN CE EAGLE KEYSER WAS LANE Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1). 2/201 M 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Roy Chisholm III, 924 Seton Dr., Cumberland MD 21502 31. Date filed (Month, Day, Year) 32. Pagistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Verena A. Guild Sweitzer 10:40 AM Feb 2010 Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Center Glen Burnie Health & Rehabilitation Glen Burnie Anne Arundel . Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 M 2 X Days Hours Min. (Month, Day, 185-18-3275 87 **Director** 04,1922 Sept. Pennsylvania Usual Residence of Decedent or 28a-f show 10a. State than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director Anne Arundel Odenton 1 🗌 Yes 2 💢 No 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 912 Taxus Drive # 104 21113 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 e filed within 72 hours after tal Hygiene. ed other than "natural", c If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify. Specify: White Completed 3 XWidowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Registered Nurse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o Harry A. Munksgard Bertha Alplanalp 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catherine M. Smith / Friend 205 Burns Crossing Road Severn, MD 21144 20b. Place of Disposition (Name of cemetery, crematory or other place) Feb. 2010 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State any injury or Crownsville, MD MD Veterans Cemetery 4 Donation 5 Other (Specify) 21. Signature of Foneral Service Licenses 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ribor Walvir Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine the burial-transit death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Box 68760 for use as 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) ____ in the past 12 months? 1 Yes 2 No Pregnant at time of death Month Day Year been signed by the should be detached To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by the P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perforn death? Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 Yes 2 No 2 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA completed filled in by the funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending work 1 Yes 2 🗆 No Investigation Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifi 29d. Date signed (Month, Day, Year) 063726 maries sunmi

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DHMH 17 Rev 7/2009

Registrar

30. Name and address of person

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31. Date filed (Month, Day, Year) FEB 17 2010

ed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Feb 08 2010 11:00 A M Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Severna Park Anne Arundel 223 Kennedy Drive Social Security Number If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days June 14, 1914 1 🗆 M 2 💢 F 95 Hours 220-07-8771 Director Marvland Usual Residence of Decedent or 28a-f show 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland item 271s marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Severna Park MD Anne Arundel 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21146 USA 223 Kennedy Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: White Specify: Completed 3 XWidowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Anne Arundel permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Meany injury or other traumatic event, the Meany injury or other traumatic any ones. Elementary/Seconday (0-12) College (1-4 or 5+) County School Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Unk Ernest Whilhelm Nellie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
223 Kennedy Drive Severna Park, MD 21146 Gerald W. Smith / Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Atlantic Crematory, LIC 20a. Method of Disposition Date 2, 20c. Location - City or Town, State Feb. 1 \square Burial 2 \boxtimes Cremation 3 \square Removal from State Glen Burnie, MD 4 Donation 5 Other (Specify) 2010 21. Signatur Kuneral Service License Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or s a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No ate has been signed by the atte page 2 should be detached for Pregnant at time of death Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 2 No 3 Probably 4 Unknown Completed 1 Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? certificate 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Tes 2 No Other: 욘 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) eral Director: After this filled in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate; 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗆 Yes 2 🗌 No ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 7/2009

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and address of person who completed cause of death (Item 23a) (Type, Print)

gistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Year **Physician** Month February 5,2010 9:40 Alan Harold Sussman /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery

9. Birthplace (State or Foreign Country) Genesis Elder Care Silver Spring
If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 X M 2 □ F Director 83 11/21/1926 MD 578-24-3328 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the "sectical Examination and the motified at Director 1 X Yes 2 □ No Silver Spring
10f. Zip Code MD Montgomery 10e. Street and Number 10g. Citizen of What Country? 20906 Leisure World Blvd. #108 USA death 12. Was Decedent Ever in U.S. Armed Forces? 1 12 Yes 2 □ No If Yes, Give Year or Dates. 1944 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. nt: If item 27 Is marked other than "natural", or Ite 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify Specify 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sales Person Retail Auto 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ida Crystal <u>Sidney Jack Sussman</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5005 Green Mountain Cir. Columbia MD 21044 <u> Vicki Sussman / Daughter</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any Injury or ot
once. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Judean Memorial Grdns: 02/09/2010 Olney, MD Kert Blake 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Edward Sagel Funeral Direction MO1477 1091 Rockville Pike Rockville, MD 20852 a. Fart 1. Ento-the as, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Physician Aspiration Pneumonia /Medical Due to (or as a consequence of): **Examiner** Dysphagia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): certificate be executed sician and burial-trans Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) P.O. 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tohacco use contribute to the cause of death? Division of Vital Records, þ Dementia, Parkinson's disease 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy performed 1 ☐ Yes 2X No 1 ☐Yes 2 ☐No 25. Was case referred to medical examiner? Be 26. Place of Death (Check onl one) Hospital: Other: 4 🖸 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this funeral 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred s after dean.
**al Director; Aftr 1 💢 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide To the Hospital within 24 hours a To the Funeral C 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

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State Registrar 3227 Bel Pre Rd. Silver Spring, MD 20906

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February 8, 2010

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Farzana Ajmal MD,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

egistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 15,2010 REBEKAH J. STANSBERRY 5:30 P M February Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Walkersville 232 WinterBrook Drive Frederick 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 - M 2 X F Months Days Hours Min. (Month, Day, Ye March 19 Country) Virginia **Director** 45 227-98-2059 .1964 Usual Residence of Decedent 28a-f shov 10a. State 10c. City, Town or Location items 23a or 28a-f sho ner must be notified at 10d. Inside City Limits Director Maryland Frederick Walkersville 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 232 Winter Brook Dr. 21793 United States death Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian "natural", or ite Black, White, etc. 9 1 Never Married 2 X Married ☐ Yes 2 X No Baltimore, Maryland 21215-0036 72 hours after Yes, Give 1 ☐ Yes 2 X No Specify White Specify: Completed 3 Widowed 4 Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Auditor Banking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ be James Baker Barbara 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 S. Stansberry /Spouse 232 Winter Brook Dr./Walkersville, MD 21793 Robert 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any injury or ot Page 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Stauffer Crematory 4 ☐ Donation 5 ☐ Other (Specify) FEB 17,2010 | Frederick,Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Stauffer Funeral Home 40 Fulton Ave./Walkersville, MD 23a. Part Lefter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest should or heart failure. List only one cause on each line. Approximate Immedia Cause (Final Onset and Death Physician/ gall bladder METGSTGT.Z CGALER disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or iinjury that initiated events physician and the burial-transit resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Year Month Day Pregnant at time of death 1 Yes 2 No 9 Unknown been signed by the should be detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has the funeral director, page 2 performe certificate Yes 2 X No 2 🗌 No 1 🗌 Yes **Division of Vital** Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 1 🗌 Yes 2 🗶 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) after death. Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred or Attending 1 Natural 5 Pending 1 Tes 2 No 2 Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Hospital 24 hours Medical 1 Secretifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed To the I within 2 Cartifying Nursa Practioner. To the best of my knowledge, death became distinctions data and place 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00067691 rest

State Registrar

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1 A Frederick MD 21701

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Regis r r's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician RANDALL EDWARD SACHS 2010 11:10 PM eb. 6, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Upper Chesapeake Medical Center Harford Bel Air 8. Date of Birth (Month, Day, 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 1XIM 2□ F 7. Age (In yrs. last birthday) Funeral Year Months Days Hours 218-42-246 0/16/1943 Director 66 Maryland Usual Residence of Decedent r 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director MD. Harford Jarrettsville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code r than "natural", or items 23a or ? the Medical Examiner must be n 2301 Birmingham Court 21084 United States Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: Vietnam Specify Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Shop Foreman Automobile Hauling . Pages 1 and 2 should be filed v iment of Health and Mental Hygie tant: If item 27 Is marked other t jury or other traumatic event, th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Sachs Charlotte Klingelhofer ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Birmingham Ct. (Wife) 2301 Sharon E. Sachs Jarrettsville, 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If iter any injury or oth once. March 3. 4 □ Donation 5 □ Other (Specify) Cremation 2010 Hampstead, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee E.G. Kurtz & Son Funeral Madden Home, Jarrettsville. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** ARTERY ORONARY EARS /Medical Due to (or as a consequence of): Examiner HYPERTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical as attending I for use as 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy Month Year in the past 12 months? Day 4□Pregnant at time of death 5 ☐ Other (specify) □Yes 2□No been signed by the should be detached 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Monknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No s certificate has b lirector, page 2 st 24a. Was an autopsy performed To the Hospital or Attending Physician: ours after death.

Interpretation of the sertifier filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

3 ☐ Suicide

29a. Certifier

4 Homicide

6 ☐ Could not be

determined

JOHN I. EUELIUS HD 32. Registrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7600 OSLEEDRIVE SUITESOS TOWSON, HDZIZOY

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

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within 24 hours af

To the Funeral D

completely filled ii

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

2294200¢

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

12010

State of Maryland / Department of Health and Mental Hygiene-Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** March 1, 2010 Dean Stark 9:00 Ам Gordon /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Frederick

If Under 24 Hrs. Northampton Manor Health Care Center
5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) <u>Frederick</u> Birthplace (State or Foreign Country) Date of Birth (Month, Day, **Funeral** 1 X M 2 □ F Months: Days Hours Min 480-38-9805 75 Director 02/11/1935 Iowa Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location show 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the "Addeal Exemine must be notflied at Director 1 ☐ Yes 27 No MD Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21702 United States 2503 Hemingway Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ģ Specify: white 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If Item 27 is marked other than any injury or other traumatic event, Its and once. computer programmer corporate business 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mary Dankoski Alfonzo Martin Stark 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Craig Stark / son 12405 Hanford Ct., Monrovia, MD 21770 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory 3/2/2010 Smithsburg, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Keeney & Basford Funeral Nome 1000 MO1222 106 E. Church St., Frederick, MD 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Cerebrovascular disease or condition resulting in death) IWERIS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical the as IF FEMALE: for use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown page 2 should pertension 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe 1 ☐ Yes 2X No 1 ☐ Yes 2 No director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No 27. Manner of Death Other: Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) filled in by the funeral After t 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No hin 24 hours after death the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investination is morning and the course of the cause 29a. Certifier completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hiren Shah r. Frederick Momass 31. Date filed (Month, Day, Year)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Day 9 FEBRUARY 2010 2.45P LEWIS DANIEL SUNDAY Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death FREDERICK FREDERICK FREDERICK MEMORIAL HOSPITAL 5. Social Security Number If Under 1 Year If Under 24 Hrs. Date or L... (Month, Day) 6. Sex 7. Age (In vrs. last birthday 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 M 2 □ F 90 Maryland Director 220-16-2054 June Usual Residence of Decedent 10a State 10b. County death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🖰 No Frederick Frederick Marvland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21702 Funeral 7415 Sundays Lane U.S.A. 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 ☐ Yes 2 XNo If Yes, Give ould be filed within 72 hours after and Mental Hygiene.

marked other than "natural", or 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 Specify: White 1 Tes 2 No Specify: 3 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Farming Farmer 12 Be 18. Mother's Name (First, Middle, Maiden Surname)
Elsie I. Ramsburg 17. Father's Name (First, Middle, Last) 2 Clinton R. Sunday 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7415 Sundays Lane, Frederick, MD 21702 Mrs. Margaret S. Sunday, wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Mount Olivet Cemetery Feb. 23, **2**010 Frederick, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Line 22. Needed and Basford PA Funeral Home M00255 106 East Church St., Frederick, MD 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Dhennon 44 Medical resulting in death) Due to (or as a co Examiner Sequentially list conditions, Examine Due to (or as a sonsequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burlar-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Dav Year 2 No 9 Unknown sate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 To 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 🗌 Yes 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 2 No ျှ 1 Tes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28c. Injury at work? Certificate: 28a. Date of injury 28b. Time of 28d. Describe how injury occurred (Month, Day, Year) Natural injury 5 Pending 1 Yes 2 No 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 16428 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Casper E. Cline III, M.D., 300 West Ninth Street, Frederick, MD 21701

Registrar
DHMH 17 Rev 7/2009

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State

31. Date filed (Month, Day, Year)

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2010

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ RONDAL LEON TETER Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Allegany Western MD Regional Medical Center Cumberland Funeral Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Hours 1170271916 West Virginia Director 705-12-2734 93 Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Mineral Ridgeley 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Route 1, Box 248 26753 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 X Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Brakeman & Engineer Railroad Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Celestine Bonner Ira Franklin Teter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ellen Whetstone / Friend 12705 Leakes Alley, S.W., Frostburg, MD 21532 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of I Important: If its any injury or ot 1 ★ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sunset Memorial Park 03/02/2010 Cumberland, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility al Service, P.A. <u>1302 National Highway, LaVale, MD</u> 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Pitrysician disease or condition ew day Medical resulting in death) Due to (or as a consequence of): **Examiner** Endstag e rendl disease Few Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of To the Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Year Month Day Pregnant at time of death Yes 2 No 9 Unknown been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Advanced age 2 No 3 ☐ Probably 4 ☐ Unknown Completed 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a, Was an Was an autopsy performed has Director: After this certificate 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? 2 X No မ 1 Donatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral! 28a. Date of injury (Month, Day, Year) . Manner of Death 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural 5 Pending Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29c. License number 29d. Date signed (Month, Day, Year) D46346

DHMH 17 Rev 7/2009

State

Registrar

Dic

Huma Shakil, M.D., 625 Kent Avenue, Cumberland, MD

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

MARO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 5:44am ZELMA BLANCHE TOMPKINS ebruan 46 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Plata narles La | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | MAY 21, 1912 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 👽 F 97 483-46-5239 Director MO. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examinating positive at IOWA Director HARDIN IOWA FALLS 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1614 SANFORD DRIVE Funeral 50126 U.S.A. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No þ Specify. Specify:WHITE 3 ₩idowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ns any injury or other traumatic event, Ite Modit once. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) MOVIE THEATER CASHIER MOVIE THEATERS 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be CHARLES I. SPENCER ပ VIRGIL SPENCER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RICH TOMPKINS-SON 4345 EAGLE CT. WALDORF, MD. 20603-4536 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4☐Donation 5 ☐Other (Specify) GIBBS. CEMETERY 3-7-2010 GIBBS, MISSOURI 21. Signature of Funeral Service Licensee M00479 22. Name and Address of Facility RAYMOND FUNERAL SERVICE, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 50 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Examiner Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last burial-trar Due to (or as a consequence of): Physician/Medical the use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☑ No by the 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ś 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 100 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 1 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P After the 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 ☐ Pending investigation 1- Natural 1 ☐ Yes 2 ☐ No after death Director: 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

certificate be executed Box 68760 o ۵. of Vital Records, Hospital or Attending Physician: Division death. within 24 hours aft To the Funeral Di completely filled in

attending physician

has

certificate

death with the Maryland

Baltimore, Maryland 21215-0036

State Registrar

Medical

29a. Certifier

Kamak

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

4

DHMH 17 Rev 1/2001

34

and manner stated.

6621

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

26

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			101	partment of Health and I	Mental Hygie	ne octo		
			Tregion a.	ertificate of Death	Reg.	No.2010 06589		
Р	hysicia Medic		1. Decedent's Name <i>(First, Middle, Last)</i> Elizabeth Ann Vickers		2. Date of Death February	3. Time of Death 02:05 A M		
	Examin		4a. Facility Name (if not institution, give street and number) 3724 Nile Road	4b. City, Town, or Location of Death Davidsonville	1	4c. County of Death Anne Arunde1		
	uneral irector		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda) 160-36-0642 7. Age (In yrs. last birthda) 7. Age (In yrs. last		8. Date of Birth 04/05/194	9. Birthplace (State or Foreign Pennsylvania		
			Usual Residence of Decedent		04/03/17-	5 125, 17.424		
faryland	8a-f sho tified at	Director	10a. State 10b. County 10c. City, Town or Maryland Anne Arundel Da	_{Location} vidsonville		10d. Inside City Limits 1 ☐ Yes 2 ☐ No		
with the N	s 23a or 2 ust be no	Funeral Di	10e. Street and Number 3724 Nile Road	10f. Zip Code 21035	un Un	Citizen of What Country?		
36 ifter death	Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 Never Married 2 Married Armed Forces? 1 Yes 2 M No	3. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto 1 Yes 2 No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc.		
	atural cal Ex	eted	3 ☐ Widowed 4 ☐ Divorced Year or Dates.	cedent's Usual Occupation	140	Specify: White		
1215-0036 thin 72 hours after ene.	than "na he Medi	Completed	(Specify only highest grade completed) (Gin Elementary/Seconday (0-12) College (1-4 or 5+)	re kind of work done during most of won DO NOT use retired) emaker	king	b. Kind of Business Industry Home		
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t, Mal	n 27 is r ier traun			alling Address (Street and Number or Ru Nile Road, Davids	ral Route Number, City Sonville, M	y or Town, State, Zip Code) laryland 21035		
Saltimore, permit. Page 1 and Department of Hea	ant: If iter ary or oth			position (Name of rematory or other place) rematory 02/1	I .	c. Location - City or Town, State Igewater, Maryland		
bait permit. Departr	Importa any inju		21. Signature of uneral Service Licensee	22. Name and Address of FacilityGeo 2973 Solomons Isla	•			
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uted	nd ransit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events c.					
pe exec	sician ar burial-t	dical E	resulting in death) Last Due to (or as a consequence of):					
oo/ou	g phy as the		- 0					
DIVISION OF VITAL RECORDS, P.O. BOX 08/00 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.	To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year		
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The la	cate ha	Com			performed	death?		
Ital ician:	ector,	Be	25. Was case referred to medical examiner?	26. Place of Death (Chec				
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DIVISION OF tal or Attending Pl rs after death.	al Direct ed in by 1		3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, so building, etc. (Specify)	treet, factory, office	28f. Location (Street City or Town, St	t and Number or Rural Route Number, tate)		
he Hospi in 24 hou	he Funer	Medical	29a. Certifier (Check only one) 1	estigation, in my opinion, death occurred a	at the time, date and pla	ace, and due to the cause(s) and manner stated.		
To t	To		29b. Signature and title of Striffier Whise Buch, MD	29c. License number D 46052	29d.	Date signed (Month, Day, Year)		
_	8W		30. Name and address of person who completed cause of death (Item 23a) (Type	Golgely Ave, #121	annapoli	13, 140		
F	Stat Registra	e	31. Date filed (Month, Day, Year) FEB 17 2010	w				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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	Physicia	ın/	Decedent's Name (First, Middle, Last) Stamatia Vrices				2. Date of Death Month February	1	3. Time of Death
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april 1			Montgomery General Hospital 5. Social Security Number 6. Sex 7. A.	ge (In yrs. last birthday)	Olney If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	Montgor	
	Funeral Director		579–54–4397 1 □ M 2 🗵 F	98 Yrs.		Hours Min.	June 6, 1	911 Gr	rthplace (State or Foreign ountry) eece
	and show lat	'n	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Loc					10d. Inside City Limits
	Maryl 28a-f	Director	Maryland Howard	Laure					1 ☐ Yes 2 No
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	death ritems ner mu		11. Marital Status 12. Was Decedent Armed Forces		Was Decedent of Hisp f Yes, specify Cuban,	anic Origin? (Spe Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amo Black, Whi	
920	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	ed by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 👿 If Yes, Give Year or Dates.	l No	Yes 2 🛣 No	Specify:		Specify: Wh:	
15-0	72 hou n "natu ledical	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give I	lent's Usual Occupation	on ing most of worki	ing	16b. Kind of Business	Industry
212	within giene. eer thai		Elementary/Seconday (0-12) College (1-4 or 0	5+) Owner	O NOT use retired)			Restaurant	
Maryland 21215-0036	should be filed on and Mental Hy, I is marked oth traumatic event	To Be	17. Father's Name (<i>First, Middle, Last)</i> Haralambos Kerosis			8. Mother's Name Demetra Ga	e (First, Middle, Ma . rras	aiden Surname)	
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Baltimore,	Page 1 an nent of He int: If iten iry or oth		20a. Method of Disposition 1 № Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Dispo cemetery, cren Parklawn I	sition <i>(Name of</i> natory or other place) Vemorial Park	C +	b. 22,	Rockville, N	
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	ne Hosp n 24 ho ne Fune pleted f	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of 2 Medical Examiner: On the basis of a Certifying Nurse Practioner: To the	examination and/or invest	igation, in my opinion,	death occurred at	the time, date and	place, and due to the	cause(s) and manner stated.
	Mithin Som	-	29b. Signature and title of certifier		29c. License nu			d. Date signed (Mont	h, Day, Year)
	1		30. Name and address of person who completed cause of		rint)	6802		a lil	
			Padmaja Bandi, 31. Date filed (Month, Day, Year) 2. Registr	MD 1811	Ul trino	ce Phi	lip Dr.	Olney	MD 20832
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		•	cate of Death		2010 06591
Physici Mèdical Exami	an/	Decedent's Name (First, Middle,Last)	-	2. Date of Death Month February 9,	Day Year
	Hei	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of De		4c. County of Death
		5415 55th Place	Riverdale	In Date of District	Prince George's
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last b	Months Days Hours	Min. 01/18	(MM/DD/YYYY) 9. Birthplace (State or Foreign Country)
		Usual Residence of Decedent	Yrs.		Mexico
w any		10a. State 10b. County 10c. City, Tow Md Prince George Rive	n or Location erdale		10d. Inside City Limits
aryland 8a-f sh	Director	10e. Street and Number	10f. Zip Code	100	g. Citizen of What Country?
eath with the Maryland items 23a or 28a-fshow any ust he notified at once.	Dire	5422 56th Ave Apt. 101	20737		Mexico
tth with tems 23	uneral	11. Marital Status 1 Never Married 2 Married Armed Forces?	13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pue		 Race - American Indian, Black, White, etc.
fter dea	щ	1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year	M∈ 1 √ Yes 2 No specify:	exico	Hispanic Specify:
hours a natura Examir	ed by		Decedent's Usual Occupation (Give kind during most of working life. DO NOT use		16b. Kind of Business/Industry
136 hin 72 e. than "	Complete	Elementary/Secondary (0-12) College (1-4 or 5+) 9th	Labor	,	Construction
5-0036 led within 7 Hygienc. other than		17. Father's Name (First, Middle, Last)		ame (First, Middle, Ma	
2121 wild be fi Mental I marked	o Be	Bulmaro Nucamendi Diaz 19a. Informant's Name/Relationship (Type, Print)	9b. Mailing Address (Street and Number	er Ventura	*
MD 2 id 2 shou ilth and ? m 27 is n	1	Maria de Lourdes Nucamendi/sist			
		1 X Burial 2 Cremation 3 Removal from State crem	e of Disposition (Name of cemetery, atory or other place)		20c. Location - City or Town, State
Baltimore, permit. Pages I at Department of He Important: If ite injury or other tr		4 Depation 5 Other Specify: 21 Signature of Funeral Service Licensee		02/22/10	Mexico
Bal Depa Impo		Many Say 1	3005 12th.ST,N.E		INES FUNERAL HOME, LLC
Physician //Medical		ga. Part I. Enter the disease, or complications that caused the death. Do failure. List only one cause on each line.	not enter the mode of dying, such as cardia	ac or respiratory arres	st, shock, or heart Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death) a. Gunshot wound of left arm Due to (or as a consequence of):	, chest, and neck		Death
~		Sequentially list conditions, b.			
	Examiner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated			
uted id ansit		events resulting in death) Last Due to (or as a consequence of): d.			
n of Vital Records, P.O. Box 68760, ing Physician: The law requires that the death certificate be executed After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial - transit	dical	UNPENDED AMENDED			
8760 ificate I	ian/Medi	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnance 1 Live birth	y 2 Fetal death 3 Ectopic pre	gnancy	23d. Date of delivery Month Day Year
OX 6 ath cert attendir or use a	용	past 12 months?	5 Other (Specify)		
O. B. 1 the de by the ached f	Phy	Part II. Other significant conditions contributing to death but not resulting	ng in the underlying cause given in Part I.	23e. Did tob	acco use contribute to the cause of death?
s, P.(irres than signed d be det	d by			1 Yes	2 No 3 Probably 4 Unknown
ords aw requas beer 2 shoul	Completed			24a. Was ar autops	y prior to completion of cause of
Rec : The l ificate b		25. Was case referred to medical	26.Place of Death (Che	1 ✓ Yes 2	
Vital ysician his cert directo	o Be	examiner?	Othor		esidence 6 🗸 Other: Scene
J of Jing Ph After funeral	n: T	27. Manner of Death 28a. Date of Injury 28b.	. Time of Injury 28c. Injury at Work? 20 hrs 1 Yes 2 No	28d. Describe ho Subject shot	ow injury occurred
isiol Attener Attener rector:	icati	2 Accident Investigation 28e. Place of Injury - At home.	farm, street, factory, office building, etc.	28f. Location (St	reet and Number or Rural Route Number, City
Div pital or ours afte eral Di	Certification:	3 Suicide 6 Could not be determined (Specify) Street		or Town, Sta 5415 55th Plac	ate) e, Riverdale, MD
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death or the Funest Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	Medical (29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or and manner stated.			
→ E3E8	Me	29b. Signature and title of certifier	29c. License number	OGME	29d. Date signed (Month, Day, Year)
		Jhodon W. King The M. 30. Name and address of person who completed cause of death (Item 23a	O.C.M.E.		February 12, 2010
		Theodore M. King, Jr., MD. Assistant Medical Exar	miner 111 Penn Street, Baltim	ore, MD 21201	
St Regis	ate	31. Date filed Month, Day Year 2010 2. Registrar's Signature	parket		
Regis	-	/10			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Febru Physician/ Billie Anderson Wilkes en 12:30 PM 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Doctors Hospital Prince Georges Lanham Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign . Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 F Min. 1 -M23-19 49 Baltimore, MD 63 218-46-9455 Director Usual Residence of Decedent shov 10a. State 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland items 23a or 28a-f sho ner must be notified at Director Prince Georges 1 Se Yes 2 No Lanham 10e. Street and Number 10f. Zip Code 10a, Citizen of What Country? Funeral 10003 Greenbelt Rd. #101 20706 <u>United States</u> Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or iter ledical Examiner n 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 3 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 1 No Specify: Yes Give Black Completed 3 - Widowed 4 - Divorced Year or Dates the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Teacher PG Schools Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Anderson Odessa Green 19a. Informant's Name/Relationship (Type, Print, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Reginald Wilkes Jr. / Son 10003 Greenbelt RD #101 Greenbelt, MD 20706 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)

Rockcreek Cementery 1 Burial 2 Cremation 3 Removal from State 2-19-2010 Washington, DC 4 Donation 5 Other (Specify) 22. Name and Address of Facility John T. Rhines Funeral Home, LLC 21. Signature of Funeral Service 3005 12th Street NE Washington, DC 20017 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Caute (Frial disease or condition resulting in death)

a. Cordinate Caute (Size Caute Cordinate Caute)

Due to (or as a consequence of): Onset and Death Physician/ Medical Examiner autension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to for as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death signed by the a I be detached g Unknown a | Unknown P.O. ed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>\$</u> Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ ₩ known Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy certificate Yes 2 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 🗌 Yes 2 No ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending 2 🗆 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3

State

Registrar

only one)

29b. Signature and title of

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PL. Tanes Pallock, SII8 Good Fuck

DHMH 17 Rev 7/2009

29c. License number

30858

29d. Date signed (Month, Dav. Year)

2010

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

		•	For State Of Ivial St		tificate of D			g. No. 2 ()	10 06594
	Physicia	n/	1. Decedent's Name (First, Middle, Last)				2. Date of Death	Pay 20,	3. Time of Death
	Medic	al	Anna WOODS 4a. Facility Name (if not institution, give street and number)		4b, City, Town, or I	Location of Dooth	raciua	Oc. County o	
	Examin	er	Washington County Hospital		Hagers			,	nington
	Funeral		5. Social Security Number 6. Sex 7. Age (Ir	yrs. last birthday)		If Under 24 Hrs. Hours Min.	8. Date of Birth		g. Birthplace (State or Foreign
	Director		062-14-2350 1 M 2 XF 89	Yrs.	Wortins Days	Hours Will.	Nov. 21	1920	New York
	nd thow at	'n	Usual Residence of Decedent 10a, State 10b. County 10	Oc. City, Town or Loc	ation				10d. Inside City Limits
	/laryla 8a-f s tified	Director	Maryland Washington	Нао	erstown				1 □ Yes 2 🔀 No
	the A	ä	10e. Street and Number		10f. Zip Code		10	g. Citizen of WI	hat Country?
	n with	Funeral	20014 Rose Bank Way Apt. 21		21742			USA	
	r iten		11. Marital Status 12. Was Decedent Ever Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 ☒ No	r in U.S. 13. W	las Decedent of His Yes, specify Cuban	panic Origin? (Spe , Mexican, Puerto	cify Yes or No- Rican, etc.)		- American Indian, , White, etc.
920	s after al", o Exam	d by	1	1	☐ Yes 2 💢 No	Specify:		Specify:	White
21215-0036	is filed within 72 hours after death with the Maryland tal Hyglene. ad other than "natural", or items 23a or 28a-f show other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	ent's Usual Occupa ind of werk done du	tion	ing 1	6b. Kind of Bus	siness Industry
2	hin 72 ne. than *	mo	Elementary/Seconday (0-12) College (1-4 or 5+)	life. DC	NOT use retired)	_	ng	_	
	d with	BeC	12 4	Reg	istered l		e (First, Middle, Ma		Lth Care
au		10	Albert Ebbinghaus			Jenny I	, ,	ideri Surriame)	
Baltimore, Maryland	2 should be file th and Mental I 27 is marked o traumatic eve		19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	g Address (Street ar			ity or Town, Sta	ate, Zip Code)
Σ			John Ebbinghaus - Brother	2216	2 Duende	Mission	n Viejo,	CA 9269	91
ore	- 5 E 2		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State	20b. Place of Dispos cemetery, crem	sition (Name of natory or other place)	Date 2	0c. Location - 0	City or Town, State
<u>=</u>	mit. Page 1 bartment of bortant: If it injury or o		4 Donation 5 Other (Specify)	Jefferson					Hills, Pa
Ba	permit. Page Department Important: I any injury or		21. Signature of Funeral Service Licensee		Name and Address 15 E. Wil		innich Fu		
		_	23a. Part 1. Enter the disease, or complications that caused the						Approximate
	-nysician/	er e	shock, or heart failure. List only one cause on each line. Immediate Cause (Final	pratory	F:1	11000			Interval Between Onset and Death
,	Medical		resulting in death)	nsequence of:	jan	MV - C			
	Examiner	Ļ	Sequentially list non-lithous	ment	Aspivat	ion Pr	eumont	9	
	od Sit	nine	if any, leading to immediate cause. Enter Underlying	onsequence of):	time lu	no de	ell ex	acesta	fai
	executed an and rial-transi	Examiner	Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a co	onsequence of):	<i>y</i> 1000	1000			777
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8760	ificate be executed g physician and as the burial-transit	Medi	IF FEMALE:)			
39 ×	ndir se	by Physician/N	23b. Was decedent pregnant 23c. If yes, outcome of p	🗌 Fetal death 3 🗌		/			of delivery
Box	e death the atter	ysic	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at tir 9 ☐ Unknown 9 ☐ Unknown	me of death 5 L	Other (specify)			Mon	th Day Year
P. O.	law requires that the nas been signed by the 2 should be detach	y Ph	Part II. Other significant conditions contributing to death but	not resulting in the ur	nderlying cause give	en in Part I.	23e. Did toba	cco use contrib	oute to the cause of death?
s,	uires t n sign		Chronic Godney &	sease			1 FYes	2 🗆 No 3	3 ☐ Probably 4 ☐ Unknown
oro G	v requ	plete	Drabetes mellitus	5			24a. Was an	24b. W	ere autopsy findings available
Ş	The lan ate has	Completed					autopsy perform 1 Yes 2	ed? de	rior to completion of cause of eath? □ Yes 2 ☑ No
g	sian: ertifica ctor, p		25. Was case referred to medical examiner?		-	ce of Death (Check			
Ξ	Physic this co	မ	1 Yes 24 No 1 Inpatient	2 ER/Outpatient		4 LI Nursing Ho	ome 5 🗌 Residen		
0	ding F h. After funera	ate	27. Manner of Death 1 ■ Natural 5 □ Pending 28a. Date of injury (Month, Day, Yellow)	(ear) 28b. Time of injury	28c. Injury work? M 1 🗆		28d. Describe how	injury occurred	1
SIO	Atten r deat cctor;	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury	- At home, farm, stre		163 2 110	28f. Location (Stre	et and Number	or Rural Route Number,
Division of Vital Records,	al or safter		building, etc. (S	Specify)			City or Town,	State)	
_	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director, After this certificate has completed filled in by the funeral director, page 2 of the physician of the funeral director, page 2 of the funeral director, page 3 of the funeral director, page 3 of the funeral director	Medical	29a. Certifier 1						
	the L	Me	only one) 3			time, date and place	e, and due to the c	ause(s) and man	ner as stated.
	5.≥6 8		29b. Signature and title of certifier	٠ من		41131	29	teb :	(Month, Day, Year)
			30. Name and address of person who completed cause of deat	-		(/	- 67 9	22,2010
21	4-10		JERRY L. CORPECTS, MI			surf, Aa	igers fav.	n, mi	21740
	Stat		31. Date filed (Month, Day, Year) FEB 2 2 2010 32. Rygistrar's	Signature					
	Registra	il I	LU & & LUIU Deneus	U. B. B	arke				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For Amend Items 23 State of Maryland / Department of Health and Maryland / Pepartment of Health and Maryland / Pepartment of Health and Maryland | Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Dav Month Harold Wise Februar Leon 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Washington County Hospital Hagerstown If Under 1 Year I If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Days Hours Dec 17, Year 936 1**X**□ M 2 □ F Marvl and 215-36-5955 Director 73 Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🙀 No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21740 11727 Walnut Point Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 X Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Board of Education Maintenance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental F is marked or ပ္ Roy M. Wise Estella Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is Robert L. Wise / Nephew 2424 Canada Hill Road Myersville, Maryland 21773 injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Boonsboro Cemetery 02/22/2010 Boonsboro, Maryland 22. Name and Address of Facility Bast-Stauffer Funeral Home, 21. Signature of Funeral Service Licens any 7606 Old National Pike Boonsboro, MD 23a. Par 1. Enter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause an each line. **Progressive Muscular Dystrophy** Approximate Interval Between Onset and Death Immediate Cause (Final tallare Physician/ disease or condition resulting in death) Medical as a consequence of complicated by Rib Fractures **Examiner** 10-11-S Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) anding physician and use as the burial-transit APPROVED BY MEDICAL EXAM that initiated events resulting in death) Last Due to (or as a consequence of): CERTIFICATION Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death Month Day Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hypertensive Atherosclerotic Cardiovascular Disease Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Diabetes Mellitus 24a. Was an autopsy performed? Yes 2 No After this certificate funeral director, pag 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 1 X Yes 2 No 1 Inpatient 2 KER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 11/29/2009 27. Manner of Death 28c. Injury at work? 28b. Time of Certificate: 28d. Describe how injury occurred Natural Accident 5 Pending To the Hospital or Attendinwithin 24 hours after death.

To the Funeral Director: Aft completed filled in by the fur **Unknown** M 1 Yes 2 XNo Subject fell. Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) **Home** 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28f. Location (Street and Number of Rural Route Number, City or Town, State) 11727 Walnut Point determined Road, Hagerstown, MD Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

FEB 22

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year Morris Wolin februare 6:40A M 2010 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Renaissance Gardens at Riderwood Village Silver Spring Prince George's If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
Month, Day, Year)
July 6, 1918 5. Social Security Number 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign Days Hours New York 052-05-2775 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits Silver Spring 1 ☐ Yes 2 No Maryland Montgomery 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 20904 3122 Gracefield Road, CT-T09 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 1 ☐ Never Married 2 ☐ Married 1 □X/es 2 □ If Yes, Give Year or Dates: 2 WWII Specify: White 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Mechanical Engineer **HVAC** 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Meyer Jerome Wolin Tillie Schiff 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ~20886Kenn Wolin -son 20321 Pleasant Ridge Drive Montgomery Village, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Judean Memorial Gdns. 2/16/2010 Olney, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Md. 20705 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Wonic nulmonaru disease or condition resulting in death) Due to (or as a consequence Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated asserts Due to (or as a consequence of): 1055 that initiated events resulting in death) Last mass IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 No 1 □ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred

/Medical Examiner The law requires that the death certificate be executed and -tran burial-1 physician s the burial attending p for use as P.0. ed by the signed to Division of Vital Records,

has

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certifica completely filled in by the funeral director, p

page ; certificate

Examiner

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Certification: To

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28a-f show

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r than "natural", or items 23a or 28a-f sho

"natural", or

permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important; If fem 27 is marked other tha any injury or other traumatic event, ITAL ODGE.

Physician

within 72 hours after

Baltimore, Maryland 21215-0036

5 Pending investigation 6 ☐ Could not be

determined

28c. Injury at Work? 1 ☐ Yes 2 No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

2 Accident

3 ☐ Suicide

4 ☐ Homicide

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier

59524

29d. Date signed (Month, Day, Year) tebruary

12,2010

humana 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

LOVEEN J-PUTHUMANA 3110 GRACEFIELD ROAD, SILVERSPRING, MD 20904

State Registrar 31. Date filed (Month, Day, Year) FEB 17 2010



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death FEB Physician/ CLED WEST WILLIAM 2010 235 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death OLNEY MONTGOMERY MONTGOMERY CrENERAL HOSPITAL 5. Social Security Number 7. Age (In yrs. last birthday) If Under Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 8. Date of Birth **Funeral** Days Hours Min Dec 3, Year 926 ^{Count}Georgia 1**X** M 2 □ F Months 129-16-0407 83Yrs. **Director** Usual Residence of Decedent shov within 72 hours after death with the Maryland aţ 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director er than "natural", or items 23a or 28a-f s the Medical Examiner must be notified 1 Yes 2 😾 No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3100 North Leisure World Blvd., 20906 USA #1019 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

14 Yes 2 No
If Yes, Give
Year or Dates. 1945-66 Black, White, etc. ğ 1 Never Married 2 Married Maryland 21215-0036 Specify: White 1 Yes 2 No Specify: Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Communications Officer Federal Government permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ George West Ruth Farnell Silver Spring, MD 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3100 North Leisure World Blvd., Apt. 1019 Barbara Maria West/Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Arlington National
Cemetery 1 XBurial 2 Cremation 3 Removal from State Feb. 25 2010 4 Donation 5 Other (Specify) Arlington, VA Signature of Funeral Service Licenses Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part NEnter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician FAILURE CONGESTIVE HEART disease or condition) Medical resulting in death) Examiner CARDIOMYOPATHY 13CHEMIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) DISEASE The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events ORONARY TERY Due to (or as a consequence of) resulting in death) Last Physician/Medical DIABETES Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ METASTATIC PROSTATE CANCER 1 Yes 2 No 3 Probably 4 Nonknown Completed CHRONIL RENAL FAILURE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed 1 Yes 2 No Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completed filled in by the funeral director; 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manney-of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 10 D59418

State Registrar

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sewwww.ms

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

O. ADEWUNMI

ULUYEMISI

FEB

17

31. Date filed (Month, Day, Year)

FEBRUARY 12, 2010

MONTGOMERY CHENERAL HOSPITAL

		State of Maryland / Department of F State Certificate of	lealth and M	-	ne I I	06598
Physici	an	1. Decedent's Name (First, Middle, Last)			Day Year	3. Time of Death
/Medic	al	Lillian Weinmann 4a. Facility Name (If not institution, give street and number) 4b. City, Town, o	or Location of Death	res	4c. County of Death	7 - 17 - 1
Examili	iei		ethesda			ntgomery
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) ff Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye	ar) 9. Birth	pplace (State or Foreign untry)
Director		120-16-1495 IDM 2 LAIF 85 Yrs. Usual Residence of Decedent		12/15/192	24	New York
show		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
he Ma	Funeral Director	Maryland Montgomery Be 10e. Street and Number 10f. Zip Code	ethesda	100	Citizen of What Cou	
3a or 3	וֹם	9707 Old Georgetown Road, #2408	20814	109.		s.A.
death	nera	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of H If Yes, specify Cubi		ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White	ican Indian,
s after or Ite	by Fu	1 Never Married 2 Marned 1 Yes 2 No 1 Yes 2 No			Specify:	
72 hours after death with the M "netural", or Items 23s or 28s-f	ed b	15. Decedent's Education 16a. Decedent's Usual Occup	pation	16b	. Kind of Business/i	White ndustry
thin 7.	Completed	(Specify only highest grade completed) (Give kind of work done life. DO NOT use retired life. DO NOT use retired life.	d)	ing		
be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Exam har must be notified at		17. Father's Name (First, Middle, Last)		e (First, Middle, Maid		Home
ally allowers. 2 should be filed within and Mental Hygiene. 1e marked other than aumatic event, the Mental aumatic event, the Mental aumatic event, the Mental aumatic event.	To Be	Charles Klein		Jeanette F		
should and Men e marks	-	19a. Informant's Name/Relationship (<i>Type, Print</i>) 19b. Mailing Address (<i>Street</i>				ip Code)
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 ie marked other than "natural", or Items 23s or 28s-f show any njury or other traumatic event, the Marical Examinar must be notified at once.		Susan Weinmann - Daughter 6710 Old Sta				
or off		20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other plants)			Location - City or 1	
it. Pages artment of artant: If II njury or c		4 Donation 5 Other (Specify) 21. Signature of Funeral Service Ucense 22. Name and Addre				l Home, Inc.
						ng, MD 20904
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dyll shock, or heart little. List only one cause on each line.	ng, such as cardiac	or respiratory arrest,		Approximate Interval Between
Physician		Immediate Cause (Final disease or condition resulting in death) a. Congestive Heart Failure				Onset and Death
/Medical Examiner		Due to (or as a consequence of):				
	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
ocuted nd transit	Examiner	that initiated events C.				
te be executed ysicien and he burial-transit	cal Ex	Due to (or as a consequence of):				
To the Hoepital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the tuneral director, page 2 should be detached for use as the burial-transit		d				
w requires that the death certificate been signed by the attending phys should be detached for use as the	Physician/Medi	fF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnance	v		23d. Date of deli	
ie deai the att	sicia	in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown 1 □ Yes 2 ☑ No	7		Month	Day Year
that the ed by		Part II. Other significant conditions contributing to death but not resulting in the underlying cause give	ven in Part I.	23e. Did tobac	co use contribute to	the cause of death?
requires i	ed by	Chronic Obstructive Pulmonary Disease		1 🗆 Yes	2 🗓 No 3 🗆 Pro	obably 4 Unknown
law regas bee	Completed			24a. Was an autopsy	24b. Were au	topsy findings available
The cate ha	Com			performed 1 ☐ Yes 2 🔀	death?	2 □ No
VIIC sician certifi rector	Be	25. Was case referred to medical examiner? Hospitaf: Use 2/15/16/16/16/16/16/16/16/16/16/16/16/16/16/		th (Check only one) ome 5 Residence	2 1 /10 u (0	Retirement
g Phys er this	n: To	27. Manner of Death 28a. Date of fnjury 28b. Time of 28c. Injury		28d. Describe how i		Home Home
Attending at death. ector: Atte by the fune	atlo	2 ☐ Accident investigation M 1 ☐	Yes 2 No			
or Att	Certification:	3 Suicide 6 Could not be determined 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Stree City or Town, S		ral Route Number,
ours a		29a. Certifier 1XX Certifying Physician: To the best of my knowledge, death occurred at the tr	me, date and place,	and due to the caus	e(s) and manner as	stated.
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my one) and manner stated.				
To the To the comp	Σ	29b. Signature and title of certifier 29c. Licens			Date signed (Month	
10			035791	F	ebruary 1	5, 2010
		30. Name and address of berson who completed cause of death (Item 23/a)/(Type, Print) Merlyn Vemury, MD, 9801 Georgia Avenue, Suit	o 227 Si	lver Spri	na. Marul	and 20902
Sta		31. Date filed (Month, Day, Year) 32 Registrar's Signature			-57	
Regist	rar	FEB 17 2010 Detern B. Sales.				

DHMH 17 Rev 1/2001

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			For State Registrar		State of Ma	arylan			nt of H e of D		and M		gien Reg. N	201	0	06599
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6.	Medic Examin		4a. Facility Name (if	not institution, give	street and number)	.17	1 4.	4b. City	Town, or	_ /	of Death	Ud		c. County of	Death	
1	Funeral		5. Social Security N	umber 6. S			La le ast birthday)	If Unde	YLLS r 1 Year Days	122	r 24 Hrs.	8. Date of Bir	th	Wico		lace (State or Foreign
	Director		216-34-4 Usual Residence of	090	X M 2 □ F	71	Yrs.	Months	Days	Hours	WIIII.	3/16/	1938	3	Court	MD MD
	yland -f show ed at	ctor	10a. State	10b. County			, Town or Lo	cation							. 10	0d. Inside City Limits 1 ☐ Yes 2 🛣 No
	the Mar or 28a e notifi	Director	MD 10e. Street and Nun	Worceste	er	Be	erlin	10f. Zi	p Code				10g. C	Citizen of Wha	it Coun	
	h with is 23a nust b	Funeral	5940 Sou	ıth Point					21811					SA		
980	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status1 Never Marri3 Widowed	ied 2 X Married 4 Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 X If Yes, Give Year or Dates.		ŀ	f Yes, spe	dent of His cify Cubar 2 🛣No	n, Mexica	ın, Puerto F	cify Yes or No- Rican, etc.)		14. Race - A Black, N Specify:	White, e	
15-0	72 hou n "natu Aedical	Completed		15. Decedent's E ecify only highest gr	ade completed)		16a. Deced	lent's Usu kind of wo O NOT us	rk done d	ition uring mo	st of workin	ng	16b.	Kind of Busin	ess Ind	lustry
212	l within ygiene. her tha t, the N		Elementary/Seco		College (1-4 or 5	+)	Owner			•			En	trepre	neu	<u>r</u>
and	be filed ental Hy ked otl ic even	To Be	17. Father's Name (I	First, Middle, Last) Hyder W	entz						her's Name L Cowa	(First, Middle, n	Maidei	n Surname)		
Thomas Wentz Baltimore, Maryland 21215-0036	should n and M ris mai raumat		19a. Informant's Na	ame/Relationship (7	ype, Print)			-	,	nd Numb	er or Rural	Route Numbe				ode)
Nomes, N	1 and 2 f Health item 27 other t		20a. Method of Disp			20b. P	lace of Dispo	sition (Na	me of			Berlin		D 2181 Location - Cit		wn, State
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Bal	permit Depar Impor any in once.	2. 3	21. Signatur of Fur	neral Service Licen:	cherd		22	. Name ai	nd Addres √i]]i	s of Facil am S	^{ity} Bur t., B	bage French	une: MD	ral Hor 21811	ne	
			shock, or hear	rt failure. List only o	plications that caused one cause on each line		n. Do not ente	er the mod	de of dying	, such as	s cardiac or	respiratory ar	rest,			Approximate Interval Between
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, P.O.	es that the igned by be detaction	l by Pł	Part II. Other signif	ficant conditions	ontributing to death be	ut not resi	ulting in the u	nderlying	cause giv	en in Par	t I.					e cause of death?
ords	v requin s been s should	Completed										24a. Was	an	24b. Wer	e autor	sy findings available
Rec	The lay	Com										auto perfo 1 Yes	psy ormed?	dea	th?	2-PNo
/ital	/sician: s certifi director	To Be	25. Was case referre examiner?	ed to medical	Hospital:	ent 2 🗆	ER/Outpatier	nt 3 🗆 🗅	Othe	r.	ath (Check	o <i>nly</i> one) me 5 □ Resi	dence	Other (S	Specify	Hospica
J of \	ling Phy .r After this funeral c	ate: T	27. Manner of Death	5 Pending	28a. Date of injur (Month, Day	γ	28b. Time of injury		28c. Injury work		2	8d. Describe I		1	эрсснуу	(1
Division of Vital Records,	or Attenctive death	Certificate:	2 Accident 3 Suicide 4 Homicide	6 Could not be determined		ry - At ho . (Specify)	me, farm, stre	M eet, factor		res 2L		28f. Location (S City or Tov			r Rural	Route Number,
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	the Hotelin 24 the Fu	Mec		dertifying Nur	se Practioner: To the I			death occu		time, dat			ne cause		er as sta	
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			For State Registrar	State of M	aryland		artment of tificate of		and M		giene Reg. N	LOIL	066	00
	Physicia	n/	1. Decedent's Name (First, Middle, L.	·-				-		2. Date of Dea	ath	^{ay} 2010 ^{Year}	3. Time of Dea 11:08A	
a constraint of the	Medic Examin	al	Fred George A 4a. Facility Name (if not institution, gir				4b. City, Town,	or Location o	of Death	March		c. County of Deatl		IVI
	<i>i</i>		Suburban Hospi			41:45	Beth If Under 1 Yea	esda If Under:	04 Hrs. I	0 D-1 (D)-		lontgome		
	Funeral Director			Sex 7. Ag	88	st birthday) Yrs.	Months Days		Min.	8. Date of Birt January	1^{Y}	1922 Peni	nplace (State or For Isylvania	
	nd thow at	J.	Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Loc	ation						10d. Inside City Lir	mits
	Maryla 28a-f s otified	Director	Maryland Montgo	mery			В	ethesd	а				1 🗆 Yes 2 🖸	₫ No
	with the 23a or	Funeral D	10e. Street and Number 6304 Orchid Dri	ve			10f. Zip Code 2081	7				itizen of What Co nited Sta		
920	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	If You Give		11	Vas Decedent of Yes, specify Cul	oan, Mexican	, Puerto R	ify Yes or No- ican, etc.)		14. Race - Amer Black, White Specify: Whi	, etc.	
21215-0036	thin 72 hou ene. • than "natu he Medic al	Completed	15. Decedent's (Specify only highest of Elementary/Seconday (0-12)		5+)	(Give I life. D	lent's Usual Occu kind of work done O NOT use retired rapher/T	during most (1)		9		Kind of Business		
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Baltimore, Maryland	id 2 should salth and M n 27 is ma er traumat		19a. Informant's Name/Relationship Marilyn I. Alber									or Town, State, Zip		
imore	Page 1 an ment of He iant: If iten ury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		20b. Pl Mor Cre	metery, cren	sition (Name of natory or other pl CY Lum, Inc	ace)	Marc 201	h 5,	Ве	cthesda,	Marvland	
Balt	permit. Depart Import any inj		21. Signature of Funeral Service Lice	nsee	M014	198 B	Name and Add	ess of Facility Chevy Mary 1	yRobe Chas	rt A 208 a	Pump 7	phrey fur 557 Wisc	neral Hom onsin Ave	e/ nue
	h, sician		23a. Part 1. Enter the disease, or co shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each lin	d the death e. pulmo	n, Do not ente							Approximate Interval Betweer Onset and Death	1
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ds, P.O.	requires that the de been signed by the should be detached	ed by Pł	Part II. Other significant conditions	contributing to death t	out not resu	ulting in the u	nderlying cause	given in Part I	l.				the cause of death	
of Vital Records,	The law rec cate has bee page 2 sho	Completed by								24a. Was autop perfo 1 \(\sum \text{Yes}	psy ormed?	prior to death?	opsy findings availa completion of cause 2 No	able of
/ital	Physician: The lar this certificate ha ral director, page 2	To Be	25. Was case referred to medical examiner? 1	Hospital:	iont of \$t	ER/Outpatier	In	Place of Deat				6 ☐ Other (Spec	(6.)	-
on of \	nding Phy ath. r. After this e funeral d	Certificate: T	27. Manner of Death 1 X Natural 5 Pending 2 Accident Investigati	28a. Date of inju (Month, Da	ıry	28b. Time of injury	28c. inj		28	3d. Describe h			17)	
Division	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completed filled in by the funeral	al Certif	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		ury - At hoi c. (Specify)	me, farm, stre	eet, factory, office)	2	8f. Location (S City or Tox		nd Number or Ru e)	ral Route Number,	
	To the Hospi within 24 hou To the Funer completed fill	Medical	(Check 2 Medical Example only one) 3 Certifying No.	nysician: To the best of miner: On the basis of e urse Pragtioner: To the	examination	and/or invest	igation, in my opi leath occurred at	nion, death oc the time, date	curred at t	he time, date a	and place e cause	e, and due to the es(s) and manner as	ause(s) and manner stated.	stated.
	7 vit		296. Signature and title of certifier	Male	~	2	03	Se number	4			rch 3, 2		
(1)			30. Name and address of person who James M. Saland	der, M.D.	1111	9 Rock	ville P	ike, R	ockvi	lle, M	lary	land 208	52	
	Sta Registra		31. Date filed (Month, Day, Year) MAR 0 5 2010	32. Registr	ar's Signati	ure park								

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State of Maryland / Department of Health and Mental Hygiene

		•	For State Of Ivial yial to	Certificate of			g. No.2	16601			
	Physicia		Decedent's Name (First, Middle, Last) Florence	Lenore Ale	vato	2. Date of Death Month	Day Year	Time of Death			
and the same of	Medic Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town,	or Location of Death	March	1, 2010 4c. County of Death	7:45 P'''			
			6913 De1vale Place 5. Social Security Number 16. Sex 17. Age (In vrs. las	Dunda Junda	a1k r I If Under 24 Hrs.	0.0.1. (10:4)	Baltimore				
	Funeral Director		5. Social Security Number 236-14-8671 Usual Residence of Decedent 6. Sex 1 M 2 F 88	Yrs. Months Days		8. Date of Birth (Month, Day,) Feb. 22					
	yland -f show ed at	ctor		Town or Location	Dunda1k			Inside City Limits			
	the Mar or 28a se notifi	Funeral Director	10e. Street and Number	10f. Zip Code		10	g. Citizen of What Country?				
	ath with ems 23a r must b	unera	6913 Delvale Place 11. Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of	21222 Hispanic Origin? (Spec	cifv Yes or No-	United State				
21215-0036	e filed within 72 hours after death with the Maryland tal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed by F	1 Never Married 2 Married 1 Never Married 2 Married 1 Yes 2 No 1 Yes, Give Year or Dates.	If Yes, specify Cub	Hispanic Origin? (Spectorn, Mexican, Puerto Folian, Specify:	Rican, etc.)	Black, White, etc. Specify: Whi				
215-	n 72 ho an "nat Medica	mple	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+)	16a. Decedent's Usual Occu (Give kind of work done life. DO NOT use retired	during most of working)g 1	6b. Kind of Business Indust	ry			
21	iled within Il Hygiene. I other than	ادها	12 Years	Assembler			Manufacturi	ing			
Maryland	be filer ental H ked ot ic ever	To B	17. Father's Name (First, Middle, Last) Luigi Mancuso		1	(First, Middle, Ma 11a Impe	n, Maiden Surname) periale				
ary	should be file n and Mental H 7 is marked o raumatic eve		19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Stree 6913 Delva	t and Number or Rural	Route Number, C	City or Town, State, Zip Code	722			
45	ealth m 2 her t		, , , , , , , , , , , , , , , , , , ,	6913 Delva.							
Baltimore,	permit. Page 1 a Department of H Important: If ite any injury or otl	983	1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Cer 4 ☐ Donation 5 ☐ Other (Specify)	2010	20c. Location - City or Town, State Baltimore, Maryland						
Ba	perm Depa Impo any ii	1 8	21. Signature of Softeral Service Ricensee	22. Name and Addr Duda-Ruc 7922 Wi	ess of Facility k Funeral se Ave. Dui	Home of	Dundalk, Inc aryland 2122	2			
	Medical Examiner	. 25	23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequent	Do not enter the mode of dy			t, Ap	proximate erval Between let and Death			
		iner	Sequentially list conditions, if any, leading to him ediate cause. Enter Underlying	Inde city:							
	ificate be executed g physician and as the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence)	nce of):							
8760	ificate be executed g physician and as the burial-transi	Aedical	d								
Box 6	ath cert attendir for use	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnance 1 Live Birth 2 Fedal of 4 Pregnant at time of decent pregnance 1 Live Birth 2 Fedal of 4 Pregnant at time of decent pregnance 1 Live Birth 2 Fedal of 4 Pregnant at time of decent pregnance 1 Live Birth 2 Fedal of 4 Pregnant at time of decent pregnance 1 Live Birth 2 Fedal of 4 Pregnant at time of decent pregnance 1 Live Birth 2 Fedal of 4 Pregnant at time of decent pregnance 1 Live Birth 2 Fedal of 4 Pregnant at time of decent pregnance 1 Live Birth 2 Fedal of 4 Pregnant at time of decent pregnance 1 Live Birth 2 Fedal of 4 Pregnant at time of decent pregnance 1 Live Birth 2 Fedal of 4 Pregnant at time of decent pregnance 1 Live Birth 2 Fedal of 4 Pregnant at time of decent pregnance 1 Live Birth 2 Fedal of 4 Pregnant at time of decent pregnance 1 Live Birth 2 Fedal of 4 Pregnant at time of decent pregnance 1 Live Birth 2 Fedal of 4 Pregnant at time of decent pregnance 1 Live Birth 2 Fedal of 4 Pregnant at time of decent pregnance 1 Live Birth 2 Fedal of 4 Pregnant at time of decent pregnance 1 Live Birth 2 Fedal of 4 Pregnant at time of decent pregnance 1 Live Birth 2 Fedal of 4 Pregnant at time of decent pregnance 1 Live Birth 2 Fedal of 4 Pregnant at time of decent pregnance 1 Live Birth 2 Fedal of 4 Pregnant at time of decent pregnance 1 Live Birth 2 Fedal of 4 Pregnant at time of decent pregnant at time of	death 3 Dectopic pregnar	ncy		23d. Date of delivery Month Day	y Year			
	requires that the de been signed by the should be detached	þ	Part II. Other significant conditions contributing to death but not result	ting in the underlying cause o	given in Part I.		acco use contribute to the case 2 10 3 Probabl				
of Vital Records,	The law ate has page 2	Completed				24a. Was an autopsy perform 1 Yes 2	ed? death?	etion of cause of			
/ital	Physician: The this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: Input inst 2 In	_ lot	Place of Death (Check						
Jo!	ing Phy fter this ineral d	ate: To	i Li inpatient 2 Li Li	R/Outpatient 3 DOA 28b. Time of injury 28c. Inju	ıry at 2	ne 5 A Residen 8d. Describe how	ce 6 Other (Specify) injury occurred				
Division	Attendi er death ector: A by the fi	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	M 1 Cne, farm, street, factory, office	Yes 2 No		eet and Number or Rural Rou	ite Number,			
Σ	pital or burs afte eral Dir filled in		building, etc. (Specify) 29a. Certifier 1 Certifying Physician: To the best of my knowled	des dooth assured at the fire	a data and place end	City or Town,					
	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completed filled in by the funeral director.	Medical	(Check 2 ☐ Medical Examiner: On the basis of examination a only one) 3 ☐ Certifying Nurse Fractioner: To the best of my k	and/or investigation, in my opin knowledge, death occurred at t	nion, death occurred at the time, date and place	the time, date and	place, and due to the cause(s				
	Vitto		29b. Signature and title of certifier	99c. Licen	number 44 70	93 29	d. Date signed (Month, Day, $3/2/10$	Year)			
			30. Name and address of person who don/pleted dause of death (Item 2	30 Holas	bud A	n Bo	all Mo.	2/222			
	Stat Registra		31. Date filed (Month, Day, Year) NAR 0 5 2010	parel							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland /				and M	ental Hyg	iene		
			_ State Registrar	Cert	tificate of L	1.0	06602				
	Physicia	n/	1. Decedent's Name (First, Middle, Last)					2. Date of Deat	Day	Year	3. Time of Death
	Medic	al	Alice Aderholt					lar 01,	2010		1:25 P M
	Examin	er	4a. Facility Name (if not institution, give street and number)		4b. City, Town, or		f Death			ty of Death	
	Funeral		10411 Oursler Park Drive 5. Social Security Number 6. Sex 7. Age (In yrs. last bit	irthdav)	Clinton If Under 1 Year		24 Hrs.	8. Date of Birth	•	ce Ge	orges place (State or Foreign
	Director		579-42-1651 1□M2\\$F 78		Months Days	Hours	Min.	(Month, Day,	Year) 1931	Cour	DC
	- MC		Usual Residence of Decedent					,			
	yland f sho ed at	ctor	10a. State 10b. County 10c. City, Tow								10d. Inside City Limits
	e Ma r 28a notif	Oire	DC Washi	ngto	n 10f, Zip Code						1 🔀 Yes 2 □ No
	ith th	Funeral Director						1	0g. Citizen o	f What Cou	ntry?
	ems arm	nue	100 Darrington St. SW 11. Marital Status 12. Was Decedent Ever in U.S.	13 W	20032 as Decedent of H		in? (Speci	ifv Yes or No-	USA	ace - Americ	on Indian
0	or it	by F	1 ☐ Never Married 2 ☐ Married Armed Forces? 1 ☐ Yes 2 ☒ No	lf '	Yes, specify Cuba	n, Mexican,	Puerto R	ican, etc.)		ack, White,	
$\tilde{\mathbf{z}}$	ural", LExa		3 ☒ Widowed 4 ☐ Divorced If Yes, Give Year or Dates.	1	Yes 2 🔀 No	Specify:			Specia	^{fy:} Bla	ck
0500-61212	"nat	Completed	15. Decedent's Education 16a (Specify only highest grade completed)		ent's Usual Occup and of work done o		of working	7	16b. Kind of	Business In	dustry
7	thin 7	Som	Elementary/Seconday (0-12) College (1-4 or 5+)	life. DO	NOT use retired)					1 Carr	
ס	Hygik Other ent, t	Be (12th C	leri	cai_	18 Mothe	r's Name	(First, Middle, M			ernment
yland	be fil ental rked rc ev	၉	Jesse Grear				e Gr		aden cana	110)	
Mary	hould and M s ma s ma		19a. Informant's Name/Relationship (Type, Print) 19i	b. Mailing	Address (Street a	and Number	r or Rural I	Route Number,	City or Town,	State, Zip (Code)
Σ	nd 2 sealth an 27 i		Steve Aderholt - Son 5	492	Notched	Beak (Ct.	Waldorf	, Md.	2060	l
ore	of He		20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 20b. Place of cemeter	of Dispos	ition (Name of atory or other plac	e)	Da	ite :	20c. Location	- City or To	own, State
Ē	Pagiment tant: jury c				n Nation		3-9-2	010	Suitla	and, N	1D.
baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amortant: If item 27 is marked other than "natural", or items 23a or 28a-f show amy rigury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee		Name and Addres		ral H	lome of	Maryl	and	
i	(-3.41)		23a. Part 1. Enter the disease, or complications that caused the death. Do		08 Suitl			Suitland		2074	
į,			shock, or heart failure. List only one cause on each line. Immediate Cause (Final		the mode of dynn	9, 00011 00 0	araido or	roophatory arros	,		Approximate Interval Between , Onset and Death
4	Hy sicia n/ Medical		disease or condition resulting in death) Alzheimers Dis Due to (or as a consequence							- 1	4 years
	Examiner			0.17.							
		dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying b. Due to (or as a consequence	of):							
,	cuted ind transi	хаш	Cause (Disease or initially that initiated events c.								
	ate be executed oblysician and the bunal-transit	alE	resulting in death) Last Due to (or as a consequence	of):							
5	physi the b	edic	d							_	
0	sertific nding use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy						234 5	ate of deliv	on
200	eath (icia	in the past 12 months? 1 ☐ Live Birth 2 ☐ Fetal deat 1 ☐ Yes 2 ☒ No 4 ☐ Pregnant at time of death		Ectopic pregnand Other (specify)	У				onth	Day Year
3	the d by the	hys	9 ☐ Unknown 9 ☐ Unknown								
Ĺ	s that gned se del	by	Part II. Other significant conditions contributing to death but not resulting	in the un	derlying cause giv	en in Part I.		23e. Did tob	acco use cor	tribute to th	ne cause of death?
אָ ב	equire sen si ould b	ted	<u>Diabetes</u> Hypertension					1 TYe	s 2 🛣 No	3 🗌 Prol	bably 4 Unknown
ecords,	law re nas be	Completed	- Hypertension					24a. Was an autops	/	prior to co	psy findings available mpletion of cause of
ב	The cate I							perform 1 Yes 2		death?	2 🗆 No
Q	ician certifi rector	Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: I I Inserting a FR/O		Othe	ace of Death	n (Check o	only one)			
>	Phys r this aral di	ĕ. 10	1 Impatient 2 Is ERVO	outpatient Time of	3 ☐ DOA 28c. Injury	4 LJ Nur		e 5 Resider) Hospice
5	nding ath. :: After e fune	Certificate:		injury	work	? Yes 2 □ 1	- 1	d. Describe flow	v injury occui	rea	
10151	r Atte	ertif	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, fa building, etc. (Specify)	arm, stree	et, factory, office		28	3f. Location (Stre		ber or Rural	Route Number,
Ś	oital o urs aft ral Di							City or Town,			
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, (Check 2 Medical Examiner: On the basis of examination and/or control of the basis of examination and or control of the basis of the basis of examination and or control of the basis of examination and or control of the basis of the basis of examination and or control of the basis of the basi	or investig	ation, in my opinio	n, death occ	curred at th	ne time, date and	place, and d	ue to the car	use(s) and manner stated.
	To the within To the sompl	2	only one) 3 Certifying Nurse Practioner: To the best of my know 29b. Signature and title of certifier	vieuge, de	29c. License		uriu piace,		d. Date sign		· · · · · · · · · · · · · · · · · · ·
			Defort Mitha pur	2	D00302	296			3/4/2	2010	
	5		30. Name and address of person who completed cause of death (Item 23a)								
	الم		Deborah Thompson, MD 5100 Auth W 31. Date filed (Month, Day, Year) 32. Registrar's Signature	A 700 mg	Suitland	, MD.	207	746			
	Stat Registra		MAR 0 5 2010	fact	1						

		•		Please	Type or Pri AMEND IT State of M	nt in E	Black In	delib	le Inl	5/2010	All J,WS	Copie	s Ar	e Legi	ible.		
		1	For State Registrar		State of M	aryiano			e of E		a ivie	птаг ну	gieni Reg. N	211	0	06	603
	Physicia		1. Decedent's Name	(First, Middle, La	Ano	lerso	24/					Date of De Month	, D	ay th 2	Year		of Death
	Medic Examin		4a. Facility Name (if r	ot institution, give	e street and number)	40	/	4b. City	Town, or	Location of De		LD&O		c. County		101	.01
	Funeral		5. Social Security Nur		Sex 7. Ag	le (In yrs. la:		If Under		If Under 24 H		. Date of Bir (Month, Da	rth av. Yearl	1917	9. Birthp	mail and	e or Foreign
	Director		250 - 24 - Usual Residence of D	Decedent	1 C W 2 231	77	92 Yrs.					11-8	-+9	1/0 - k	Dout		rolina
	/arylanc 8a-f sho tified at	Director	M D	10b. County		<u>ن</u>	alf	•	ore	,					1		City Limits ∕es 2 □ No
	vith the N 23a or 2 st be no		10e. Street and Numb	vick/	and R	and	/	_	p Code	229			10g. C	Citizen of W	/hat Coun	try?	
	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho er the Medical Examiner must be notified at , the Medical Examiner must be notified at	-	11. Marital Status		12. Was Decedent	_	. 13. V	Vas Dece Yes, spe	dent of Hi	spanic Origin? n, Mexican, Pu	(Specify erto Ric	/ Yes or No- an, etc.)	-		- Americ		
9036	urs after ural", o	ted by	1 ☐ Never Marrie 3 ₩Widowed 4		1 Yes 2 If Yes, Give Year or Dates.	No	1	☐ Yes	2 XNo	Specify:				Specify:	BI	ack	
21215-0036	n 72 hou e. ian "nat Medica	Completed	(Speci	15. Decedent's lify only highest garday (0-12)		5+)	16a. Deced (Give k life, DC		rk done a	ation Juring most of v	vorking		16b.	Kind of Bu	siness Ind	lustry	
d 21)	ild be filed within Mental Hygiene. Iarked other tha iatic event, the I	a l	12. Father's Name (Fi				\mathcal{S}_{ℓ}	an	15/1	18. Mother's !	Name (F	irst. Middle	. Maider	Surname	hin	9	
Maryland	uld be fil Mental narked o	၉	Elij	ah.	Tenkin.	5				Le	VII	110		/ /	nil	ton	
	1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		19a. Informant's Nan Antoinett	ne/Relationship (Type, Print) Cn (Cous	in)	19b. Mailin	og Addres	s (Street a	and Number or rick A	Rural R	oute Numbe 149	er, City c	or Town, St I Her	ate, Zip C	code)	10 ZO811
er Son Baltimore,	~ O + -	(0 8		Cremation 3	Removal from State	20b. Pl	ace of Dispo	natory or o	other plac		Date		20c.	Location -	City or To	wh, State	MD
3altin	permit. Page Department Important: I any injury o		4 Donation			<u> </u>	<u>rrisi</u>	Vame a	nd Addres	4 55 11140	-15- ccr	ne. Fi	une	vinge Val	Sen	rices	MU
Z L	<u>0</u> 0 = ∞ 0		23a. Part 1. Ent	e disease, or con	DILLINE INDICATIONS that caused	d the death	. Do not ente	515 er the mod	de of dying	Saltim	ore	Na	nor	nal	PiKe	Approxim	nate
	Physician/ Medical		Immediate Cause (Fi disease or condition resulting in death)	inal	one cause on each line DEM	ENT	IA									Interval E Onset an	
×	Examiner		Sequentially list con-	ditions	Due to (or as	a conseque	ence of):										
= 18	ted 1 Insit	Examine	cause. Enter Underly	nediate ying	Due to (or as	a conseque	ence of):								- 11		
TIL BO	e executed cian and purial-transi		that initiated events resulting in death) La	ast	Due to (or as	a conseque	ence of):										
8760	tificate by ng physi as the b	Medic	IF FEMALE:		d												
Box 68760	Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician and sted filled in by the funeral director, page 2 should be detached for use as the burial-transit		23b. Was decedent p in the past 12 m 1 ☐ Yes 2 🔀 9 ☐ Unknown	onths?	23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 Fetal	death 3 [Ectopic Other (s		у				23d. Date Mon	e of delive	ry Day	Year
, P.O	es that the signed by be deta	þ	Part II. Other signific	cant conditions	contributing to death t	out not resu	Iting in the u	nderlying	cause giv	en in Part I.		121		use contri			f death?
ords	law requir has been s le 2 should	Completed										24a. Was	an	24b. W	Vere autor	sy finding	s available f cause of
l Rec	ician: The la certificate ha rector, page :		25. Was case referred	to medical					OC DI	ace of Death (C	· · · · · · · · · · · · · · · · · · ·	perfe 1 Yes	ormed?	d	eath?		
Vita	hysicia his certi I directo	To B	examiner? 1 Yes 2				R/Outpatien	t 3 🗆 D	Othe				idence	6 ☐ Other	r (Specify)		
on of	nding Path. r: After t	Certificate:	27. Manner of Death 1 Natural 2 Accident	5 Pending	28a. Date of inju (Month, Da	iry y, Year)	28b. Time of injury	м _	28c. Injury work 1 🏻	∕at ? Yes 2 □ No	280	l. Describe	how inju	iry occurre	d		
Division of Vital Records, P.O.	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,		3 ☐ Suicide 4 ☐ Homicide	6 Could not l				eet, factor	y, office		28f	Location (City or To			r or Rural	Route Nui	mber,
	e Hospil 24 hour e Funera leted fill	Medical	(Check 2	Medical Exam	ysician: To the best of niner: On the basis of e rse Practioner: To the	examination	and/or invest	igation, in	my opinio	n, death occurr	ed at the	e time, date	and plac	e, and due	to the cau	ise(s) and i	manner stated.
	To the within To the comp		29b. Signature and ti	tle of certifier	n.D	J.J. Of Hilly		29	c. License			300 10 1	29d. D	ate signed	(Month, L		
	77		30. Name and address		completed cause of	death (Item	23a) (Type, P	rint)									
	Stat	e.	HASAN 31. Date filed (Month		2717 H	AMM ar's Signatu	ire .		278	D BAG	LTI	nort	, MI	121	27	7	
	Registra	ar	31. Date filed (Month	n 9 501(1 Senon	1.	park										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		•	For State Registrar	State of Maryland	•	tificate of L		, ,	Reg. No 2	10	06604
	Physicia		Decedent's Name (First, Middle, Last) Edward	David	A	ndrulewi	cz	2. Date of Dea Month March)1 Vear	3. Time of Death 9:11 A M
	Medic Examin		4a. Facility Name (if not institution, give streem 419 Phirne Road	et and number) West		4b. City, Town, or Glen Bu	Location of Death			y of Death Arund	.e1
	Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. Ia		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Oct. 8,	Year) 1945	9. Birthp Count	olace (State or Foreign try) MD
	land show dat	tor	Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Loc	cation				1	0d. Inside City Limits
	Many 28a-i	Director	MD Anne Aruno	le1	G1e	n Burnie					1 Yes 2 X No
	s 23a or	Funeral L	419 Phirne Road We	est		10f. Zip Code 21061			10g. Citizen of U.S.A.		try?
900	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		11. Marital Status 12 1 Never Married 2 X Married 3 Widowed 4 Divorced	. Was Decedent Ever in U.S Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates.	If	Vas Decedent of Hi FYes, specify Cuba ☐ Yes 2 💢 No	spanic Origin? (Spen, Mexican, Puerto	ecify Yes or No- Rican, etc.)	Bla	ce - Americack, White, e	etc.
Maryland 21215-0036	ithin 72 hou lene. r than "nat the Medica	Completed by	15. Decedent's Educi (Specify only highest grade Elementary/Seconday (0-12)		(Give k life. DC	lent's Usual Occup kind of work done of D NOT use retired) Cical Eng	luring most of work	ing	16b. Kind of Business Industry Department of Defense		
and 2	be filed w ental Hygi ked othe c event,	To Be	17. Father's Name (First, Middle, Last) Edward Thomas Andru	lewicz	110001	2001 1116	18. Mother's Nam		Maiden Surnan	ne)	
Mary	d 2 should alth and Ma 127 is mar		19a. Informant's Name/Relationship (Type, Mrs Sarah Ferguson				and Number or Rura				
Baltimore,	Page 1 and nent of Herant of Herant II item		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State	emetery, crem dowrid	sition (Name of natory or other place Mem.	Park 201	0	20c. Location	lge, M	D
Balti	4 Donation 5 Other (Specify) Meadowridge Mem. Park 2010 Elkridg 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Singleton Funeral Services PA 1 2nd Ave. SW Glen Bur										
4	-nysician/		23a. Part 1. Enter the disease, or complica shock, or heart failure. List only one of Immediate Cause (Final disease or condition	ations that caused the death cause on each line. NEU Due to (o as a consequ			g, such as cardiac o	or respiratory arre	est,		Approximate interval Between Onset and Death
	Medical Examiner		resulting in death) Sequentially list conditions, b.	Due to (or as a consequence to (or as a consequence to (or as a consequence)	ence of): ATIO	N					
λ,	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events	PARK	CKINSON'S DISEASE						
0	icate be executed physician and s the burial-transit	1edical Ex	resulting in death) Last	Due to (or as a consequ	ence of):						
68760		/Mec	IF FEMALE:	: If yes, outcome of pregnar	acv				1		
. Box (To the Hospital or Attending Physician: The law requires that the death certific within 24 hours atterdeath. To thin 24 hours atterdeath. To the Funeral Director. After this certificate has been signed by the attending completed filled in by the funeral director, page 2 should be detached for use as	by Physician/N	23b, Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 Live Birth 2 Feta 4 Pregnant at time of d 9 Unknown	Ideath 3	Ectopic pregnand Other (specify)	y		1	ate of delive	Day Year
ls, P.0	uires that ti n signed by ald be deta	ed by P	Part II. Other significant conditions contr		ulting in the u	nderlying cause giv	ven in Part I.	23e. Did to			e cause of death?
Division of Vital Records, P.O. Box	rsician: The law req s certificate has bee lirector, page 2 shoo	Completed		1991 - 19				24a. Was a autop: perfor	sy med?	Were autor prior to cor death? 1 \(\sum \) Yes	osy findings available mpletion of cause of
<u>a</u>	sian: T ertifice ctor, p	Be C	25. Was case referred to medical examiner?	9.1			ace of Death (Checi		22110		
Š	Physion this contained in the direction of the direction	유	1 ☐ Yes 2 ☑ No 27. Manner of Death	spital: 1 Inpatient 2 28a. Date of injury	ER/Outpatien	nt 3 DOA Othe	4 U Nursing Ho	ome 5 Residence 528d. Describe ho			
ono	ending rath. rr. Afte	ficate	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigation	(Month, Day, Year)	injury	work		zod. Bodonbo ne	or injury occur		
Divisi	tal or Atter rs after de al Directo	al Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At ho building, etc. (Specify,		eet, factory, office		28f. Location (Si City or Town		ber or Rural	Route Number,
	he Hospi in 24 hou he Funer	Medical	(Check 2 Medical Examiner	an: To the best of my knowle On the basis of examination ractioner: To the best of my	and/or invest	tigation, in my opinio	on, death occurred a	t the time, date ar	nd place, and d	ue to the cau	use(s) and manner stated.
	,		29b. Signature and title of certifier Mullussus	Jums		29c. License	54574		29d. Date sign	2/10	Day, Year)
	1541		30. Name and address of person who com MARK KIM, MD 14 31. Date filed (Month, Day, Year) MAR 0 5 2010	pleted cause of death (Item 1/2 N. CRAIN	23a) (Туре, Р Ншү	rint) 6A GLE	NBURNI	E MA	200	61	
	Sta Registra		31. Date filed (Month, Day, Year) NAD 0 5 2010	2. Registrar's Signa	ure far	Red					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Year · ODAM er 122,2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** la DN VIILE Hom If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Social Security Number Birthplace (State or Foreign Country) 6. Sex **Funeral** -20-2268 1 M 2 F Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or Items 23a or 28a-f show 1 Xes 2 No Director nai 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 12 Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1√2 Yes 2 □ V Yes, Give Year or Dates: 2 No 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes Specify. Specify 3 Widowed 4 Divorced "natural", the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry is marked other than permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other traumatic event, The M Elementary/Secondary (0-12) College (1-4or,5+) runer Usiness Th17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sht Edgewood, mD. Archer-taughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State -2010 Dungomills, mD. 4 ☐ Donation 75 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility march Fitt 23a. Pax1. Int it the disease, or complications that caused the death. Do not enter the more of dying, such as cardiac or respiratory arrest shock, or he in failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediat use (Final disease or condition resulting in death) **Physician** . END STAGE CHRONIC OBSTITUCTIVE PULMONARY /Medical Due to (or as a consequence of): **Examiner** DISLASE Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 □Yes 2 □ No Month 5 Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ funeral director, page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed Hospital or Attending Physician: The certificate 1 ☐ Yes 2 ₩ No 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident hours after death uneral Director: completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

2835

SMITH AVE BALTIMONE MID

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BURTON

32. Registrar's Signature

February 25

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death **Physician** 6:00 A M 28, FEB. 2010 SHARON ANN ANGELES /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** N/A 1407 ANGLESEA STREET BALTIMORE If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) 6. Sex **Funeral** Days Months Hours 60 1 □ M 2 T F 214-56-9578 14, 1949 Director AUG. MD. Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evantment or other traumatic event or other traumatic event or other event event or other event or other event 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 X Yes 2 No Director N/A BALTIMORE MD. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? UNITED STATES 1407 ANGLESEA STREET, 21224 APT. 2-C Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 🔀 Married <u>8</u> If Yes, Give Year or Dates: 1 ☐ Yes 2 ▼ No Specify: Specify: WHITE 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) MANAGER RESTAURANT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MARCELLA O'CONNOR CHARLES KRUG 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21224 1407 ANGLESEA STREET, BALTIMORE, MARYLAND ALFREDO ANGELES, SR./HUSBAND 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State GLEN BURNIE, MARYLAND ATLANTIC CREMATORY 02/05/2010 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CHARLES S. ZEILER & SON, INC. 21. Signature of Euneral Service Licensee 6224 EASTERN AVE., BALTIMORE, MARYLAND 21224 r complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter the dis ase shock, or hear Latter. Immediate Cause Final **Physician** disease or condition resulting in death) /Medical Due to one a consequence of): Examiner Due to s a consequence of): Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and physician and s the burial-trans Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 D Jnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a. Was an 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 □ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Natural Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Tecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

Registrar
DHMH 17 Rev 1/2001

State

30. Name and

31. Date filed (Month

5

Baltimore, Maryland 21215-0036

P.O. Box 68760.

Records,

Division of Vital

DAYWOOD

Glen Burnie MA 21061

ddress of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signatu

72845

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month February Physician/ Lauvinia Mary Burgess 28, Medical 4a, Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Holy Cross Hospital Silver Spring Montgomery Social Security Numbe If Under 1 Year I If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Days 1 M 2 X F nth, Day, 579-30-8868 82 Yrs. Jan" 1928 **Director** Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location Director MD Montgomery Silver Spring ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be n 11901 Georgia Ave. 20902 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, er than "natural", or iter the Medical Examiner Armed Forces δ 1 Never Married 2 Married Yes 2 TXNo Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify Specify: 3 Widowed 4 X Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Housekeeper Hospitality 12 other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be filed and Mental H is marked ot ဂ္ unknown Mary Virginia Glenn permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Coo 3310 Claridge Ct. Silver Spring, MD 20902 Geraldine V. Glenn (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place)
Chesapeake Crematory 20a. Method of Disposition 20c. Location - City or Town, State Feb.Da27, 1 Burial 2 Kremation 3 Removal from State 2010 Beltsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rapp Funeral & Cremation Service M00982 933 Gist Ave. Silver Spring, Maryland 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Pneumonia Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Septic Shock Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate and I-transit Acute Respiratory Failure death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last sician a burial-Physician/Medical Acute Renal Failure 09/89 phy the attending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box (3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No
9 Unknown Pregnant at time of death 4 ☐ Pregnam a
9 ☐ Unknown P.O. that the signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Records, Coronary Artery Disease, Pacemaker, Severe Peripheral 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed Vascualr Disease, Right above knee amputation, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page Cardiovascular Accident Yes 2 No 25. Was case referred to medical examiner? **Division of Vital** Be 26. Place of Death (Check only one) 2 X No Other: 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death

1 Natural
2 Accident
3 Suicide 28a. Date of injury (Month, Day, Year) To the Hospital or Attending Pleath.
Within 24 hours after death.
To the Funeral Director: After the completed filled in by the funeral 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work? 5 Pending Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Cartifying Nursa Praction the best of my knowledge, deeth consumed at the time, date and place, and 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) DAQ 990 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Schwab MD, 1500 Forest Glen Rd., Silver Spring, MD 20910 Lee E.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

2010

Black, White, etc.

Black

Approximate Interval Between Westt and Death

week

week

week

Day

1 Yes 2 No

C

Year

Month

3:30 a. M

9. Birthplace (State or Foreign

Washington, DC

10d. Inside City Limits

1 🗌 Yes 2 🎦 No

DHMH 17 Rev 7/2009

Registrar

32. Registrar's gnature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ February 28, 2010 11:35 ам Bonneau Jeanette Lavern Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rockville Montgomery Shady Grove Adventist Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** 087-56-8851 43 Days Hours Min. (Month, Day, Year) 966 Country) 1 M 2 XF Maine Nov. Director Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 🗆 Yes 2 🗒 No Maryland Montgomery Germantown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 20874 12731 Pumpkin Seed Ct. 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ 1 Yes Maryland 21215-0036 Black 1 ☐ Yes 2 No Specify: 3 Divorced 4 Divorced Completed Year or Dates 15 Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) should be filed within 72. n and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Brenda Sydnor Arthur Bonneau permit. Page 1 and 2 should be De; artment of Health and Men Important: If item 27 is marke any injury or other traumatic. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20535 Lowfield Dr. Germantown, Maryland 20874 19a. Informant's Name/Relationship (Type, Print) Brenda Sydnor (mother) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Chesapeake Crematory 20a. Method of Disposition Mar.Date 8. 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Beltsville, Maryland 2010 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rapp Funeral & Cremation Service Signature of Furjetal Service Licensee M00982 933 Gist Ave. Silver Spring, Maryland 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Cardiac Arrest disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Cardiomyopathy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) requires that the death certificate be executed Exam and that initiated events Due to (or as a consequence of): resulting in death) Last physician ar s the burial-t Physician/Medical Division of Vital Records, P.O. Box 68760 as t the attending IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death use 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Year ρ Month Day Pregnant at time of death signed by the a d be detached for 9 Unknown g V Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by End Stage Renal Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown should 24b. Were autopsy findings available prior to completion of cause of Human Immunodeficiency Virus 24a. Was an or Attending Physician: The law autopsy certificate has page 2 performed death? 2 🗌 No Yes filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 No Hospital: Other: 1 🗌 Yes ဂ္ 1 Nnpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completed filled in by the completed filled in the complete filled filled in by the complete filled Date of injury 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) injury work? 1 ☐ Yes 2 ☐ No Natural Accident 5 Pending Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. The best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Brian Carpenter, M.D.

5 201

31. Date filed (Month, Day, Year)

D64502

9901 Medical Center Drive, Rockville, Maryland 20850

March 1, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No./ 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 09:20+M 02 2010 cia /Medical 4b. City, Town, or Location of Death 4c. County of Death acility Name (If not institution, give street and number Examiner umbia, MID Howard 60 Date of Birth (Month, Day, Year, Mar 01, If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday 5. Social Security Number **Funeral** Year) 1 □ M 2 🔀 F 61 1949 Maryland 220-52-6989 Director Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, the Medical Evant has matthe at 1 ☐Yes 2 No Director MD Howard Columbia 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 21044 10334 Hickory Ridge Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White, etc. hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify ò Specify: White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) within 72 Elementary/Secondary (0-12) College (1-4or 5+) Own Home 12 Homemaker 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othe any injury or other trainmets. 17. Father's Name (First, Middle, Last) Be Fuellar Rita William Bradley 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 10334 Hickory Ridge Road Columbia, MD 21044 Nicole Bradley /Daughter Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Mar 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2010 Beltsville, Maryland Chesapeake Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Narrand Address of Farilly Funeral Alternatives M01442 8717 Green Pastures Drive Towson Maryland 21286 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final day **Physician** 05isdisease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to himmediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760. Physician/Medical the IF FEMALE If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 No the detached 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Records, by 3 Probably 4 Unknown 1 ☐ Yes page 2 should Completed been s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performer certificate 1 ☐Yes 2 ☐No 1 ☐Yes 2 ☐No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State

son who completed cause of death (Item 23a) (Type, Print) 30. Name and addre . M.D Hasan Duais 31. Date filed (Month, Day, 32. Registrar's Signature

my

and manner stated

Registrar

29a. Certifier

(Check only

29b. Signature and title of cer

Medical

29c. License number

Cedar Lane

29d. Date signed (Month, Day, Year)

Columbia

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 03-01-2010 **Physician** Thomas Brennan 110 P /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 501 Stonehue Ct Bel Air Harford If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year 06-17-1936 Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1**⊠**M 2□F 73 114-28-0720 NY Director Usual Residence of Decedent should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits 28a-f show 1 ☐ Yes 2 No notified Director MD Harford Bel Air 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ms 23a or 7 501 Stonehue Ct 7 Is marked other than "natural", or items 23a traumatic event, the Medical Examiner must b 21014 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married 1 ☐ Yes 2 🛣 No Specify Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Trainer Insurance Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Thomas J. Brennan Sr Johanna Huschle ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 Is
any Injury or other trau
once. Barbara J. Brennan (Wife) Stonehue Ct Bel Air, MD 21014 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State Bayview Crematory 03-04-2010 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signal re of Funeral Sarvice Licensee 22. Name and Address of Facility Schimunek Funeral Home of BelAir Inc 610 W. MacPhail Rd Bel Air, MD 21014 23a. Part1. Enter the disease, or complications that caused the death. Shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Kenal coll carcinetus **Physician** year disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-tran Due to (or as a consequence of) attending physician Physician/Medical the use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ▼No 24a. Was an 1☐ Yes 21 No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident Injury 1 🗌 Yes 2 🗀 No I or Attend after death Director: 3∏ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

Saltimore, Maryland 21215-0036

6 ☐ Could not be determined

Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

(Check only one) and manner stated. 29b. Signature and title of certifier

29c. License number 45530

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year) 3-2-2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Suite 200, 602, SOUTH ATWOOD, BELAIR MD, 21014 . SIVAS ATUAM

State Registrar 31. Date filed (Month, Day, Year) MAR U 5 2010

29a. Certifier

32. Registrar's Signature

within 24 hours a To the Funeral C the Hospital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March 4,2010 Isabelle Beacham 9:05A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Balto. Parkville 0akcrest 5. Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours 1 □ M 2**X**□ F Vorgania 214-24-8686 100 Director 11,1909 Tune Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f shov event, the Medical Examiner must be notified at should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Md. Balto. Parkville 1 ☐ Yes 2√☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 8800 Walther Blvd. Apt. 3417 21234 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🗓 No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2 X No Specify: If Yes, Give 3 √Widowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 9th Homemaker Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic once. Violet Pearre James Nowell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21128 DTR 9603 B Haven Farm Rd. Perry Hall, Md. <u>Joycelyn Richardson</u> 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) Bayview 3-5-2010 Balto. Md. 21. Signature of Funeral Service License 22. Name and Address of Facility Schimunek FUneral Home 1. Nottingham, Md. 21236 9705 Belair Rd. foresis 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Onset and Death Immediate Cause (Final Pnysician/)ebilit disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760
the Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical ed by the attending I IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year 5 Other (specify) Day Pregnant at time of death Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? HIM 1 Yes 2 Info 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 performed' 1 🗌 Yes 2 🗆 No certificate Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: ٥ 1 Tyes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) this Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 1 Natural 28d. Describe how injury occurred 5 Pending work 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined hours after within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. R171944 מלח ק

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

8800 Walthar Blvd, Packville, MD 21234

completed cause of death (Item 23a) (Type, Print)

CRN9 MSX

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March 1,2010 12:15P Doris Jeanette Butt Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Quail Run Asst. Living Balto. PARKville Social Security Number 6. Sex If Under 24 Hrs If Under 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours August 21,1936 Maryland **Director** 213-34-0360 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f shov event, the Medical Examiner must be notified at ld be filed within 72 hours after death with the Maryland Mental Hygiene. 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 ី No Perry Hall Md. Balto. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21128 4504 Forge Road USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. 1 Never Married 2 Married Yes 2 No Completed by If Yes, Give Year or Dates 1 ☐ Yes 2 √ No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Hospital Office Manager is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Thad W. Benefield Thelma J. Knapp injury or other traumatic .. Page 1 and 2 should b tment of Health and Mer tant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11401 Beaver Dam Rd. Union Bridge, Md. 21791 DTR. Ellen Hurdel permit. Page 1 and 3 Department of Healt Important: If item 2 any injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State 3-6-2010 Parkville, Md. Parkwood 4 Donation 5 Other (Specify) 22. Name and Address of Facility Schimunek Funeral Home Signature of Funeral Service Licenses 9705 Belair Rd. Nottingham, Md. 21236 23a art 1. Enter the disease, or complications that a used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause are each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury the attending physician and ned for use as the burial-trans that initiated events resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death Pregnam
Unknown 1 Yes 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an cate has t page 2 s autopsy certificate 1 Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 ♠ No director. æ 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital ျ 1 Inpatient 2 ER/Outpatient 3 DOA After this c 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 🚂 Natural injury 5 Pending 2 Accident
3 Suicide Director: A Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) To the Funeral C Medical 29a. Certifier 🥌 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 h To the Fur Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one To the (Type, Print) gcross roads, Baltimore, Md 21228

Registrar

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

			For	State	of Maryla	nd / Depa	artme	ent of H	lealth a	and N	/lental Hy	/gien	е		
			State Registrar			Cer	tifica	te of L	Death			Reg. N	10.2 N LJ		06613
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	Medic Examin		4a. Facility Name (if not institution		number)		4b. Cit	y, Town, or	Location o	of Death	- 002		c. County of De		
			5500 Friendsh	ip Blvd.	#1210N		C1	nevy (Chase				Montgom	ery	
	Funeral Director		5. Social Security Number 577–40–9825	6. Sex 1 M 2 4		. last birthday) Yrs.	If Und Month		If Under: Hours	24 Hrs. Min.	8. Date of Bi (Month, Da July 20	rth av, Year)	930 Was	irthplac ountry) hing	ton, D.C.
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	or 28	Funeral Director	Maryland Mor 10e. Street and Number	ntgomery		Ollevy C		Zip Code				10a C	Citizen of What (Country'	
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	death items ier m	Fun	11. Marital Status	12. Was De	ecedent Ever in U Forces?	J.S. 13. V	Vas Dec				ecity Yes or No- Rican, etc.)		14. Race - Am	nerican	Indian,
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	and Healt tem 2		Ray Barkalow 20a. Method of Disposition	/Step-Son		Place of Dispo			e Koa		Doylest	1	PA 189		State
ē	age 1 ent of nt: If i		1 Burial 2 X Crematio		om State	cemetery, cren	natory or	other plac	. 1	larcl	n 4,				
baitimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service		MOI	ntgomery (201			hesda, l esda Chev		
מ	9 9 E 8	13	74.7.4	horr		<u> 1360 1755</u>	57 Wi	sconsi	n Aver	nue,	Bethesda	ı, Ma	ryland 20	0814	ise, IIIC.
			23a. Part 1. Enter the disease, shock, or heart failure. Lis	or complications that t only one cause on	at caused the dea each line.	ath. Do not ente	r the mo	de of dying	g, such as o	cardiac c	r respiratory a	rrest,			proximate terval Between
-	Physician/	i Vi	Immediate Cause (Final disease or condition	a	Α	SCVD								Or	nset and Death
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ב	hysician: The law nis certificate has b I director, page 2 s	Cou									perfo	ormed?	death?		
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	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending prompleted filled in by the funeral director, page 2 should be detached for use as	Medical	(Check 2 Medical	ng Physician: To the Examiner: On the b	asis of examination	on and/or investi	gation, in	n my opinio	n, death occ	curred at	the time, date a	and plac	e, and due to the	cause(s) and manner stated.
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			Betsy Ballard	1, M.D. 2	101 Medi	cal Par	k D	r. #3	04, S	ilve	r Spri	ng,	Marylar	nd 2	0902
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month FEBRUARY 2010 HELEN BACKERT 11:50 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death FOREST HILL HEALTH & REHAB CENTER FOREST HILL HARFORD Social Security Number 8. Date of Birth (Month, Day, April I 6. Sex 7. Age (In vrs. last birthday) If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** Hours Min 1 M 2XX Months Days Mary Land Director 85 Yrs 183-18-6552 Usual Residence of Decedent or 28a-f show notified at and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. 10a. State 10b. County Director 10c, City, Town or Location 10d. Inside City Limits 1 Yes 2 XNo MD Harford Forest Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a o Funeral 109 Forest Valley Drive 21050 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify 3 Widowed 4 □ Divorced Specify White event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 10 Years Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Frank Skarupa Rozalia Gasior other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rosemary Arms (Daughter) 1226 Bonaire Road Forest Hill, MD Baltimore, 20a. Method of Disposition permit. Page 1 a
Department of F
Important: If ite
any injury or ott 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 🔲 Burial 2 🙀 Cremation 3 🔲 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 3/2/2010 Towson, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, 7922 Wise Ave. Dundalk, Maryland 23a. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Due to (or as a consequence of). der disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine Directo (or as a consequence of): if any leading to inmediat cause. Enter Underlying Cause (Disease or iinjury that initiated events attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown Day Year been signed by the a should be detached f Yes 2 No 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 Yes No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: Nursing Home 5 - Residence 6 - Other (Specify, 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA Director: After this Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending injury 1 Yes 2 No Investigation 6 Could not be filled in by the 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after d

To the Funeral Direct

completed filled in by 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 7/2009

Registrar

State

31. Date filed (Month, Day, Year)

DAVID DUNN

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

615 W. MACPHAIL ROAD Registrar's Signature

032295

BEL AIR, MD.

21014

Du alen 1, 2018

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 06615 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 02 Janice Y. Brockington 2010 6:04 a M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince George's Hospital Cheverly Prince George's 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth 1 □ M 2 및 F Months Days Hours Min. (Month, Day, Year) 04-07-1945 Country)
Washington. 579-62-1093 Director Usual Residence of Decedent 28a-f shov 10a. State Examiner must be notified at 10h County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Prince George's Capitol Heights Y Yes 2 No 5 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 6803 Hastings Drive 23a 20743 U.S.A. items 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. ō þ 1 Never Married 2 K Married 1 X Yes 2 ☐ No If Yes, Give Maryland 21215-0036 er than "natural", or the Medical Exam 1 ☐ Yes 2 🔀 No Specify: Specify: Black Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Customer Representative Private Be filed Department of Health and Mental H
Important: If item 27 is marked ott
any injury or other trease. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ James Young Josephine Stradford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Brockington/ Husband 6803 Hasting Drive Capitol Heights, Maryland 20743 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Washington National March 8,201 Suitland, Maryland 22. Name and Address of Facility Marshall's Funeral Home of MD 21. Signature of Funeral Service Licensee 1000A 4308 Suitland Road Suitland, Maryland 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death .Physician/ Alcoholic Liver cirrhos: 3 disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Failure Acute Renal Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): Acute 121000 ane mi a • Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
• Z4 hours after death.
• Funeral Director: After this certificate has been signed by the attending physician and eted filled in by the funeral director, page 2 should be detached for use as the burial-transit 1201 that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical eso pina peal rar; us Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death Month Day Year 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? B B 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 🛣 No Other: 유 1 X Inpatient 2 - ER/Outpatient 3 - DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a

To the Funeral Medical 29a. Certifier 🗓 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, my kernil Abdelia, mo D0059981 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Abdella, mi) 3001 Hospital DR. Cheverly, MU 20185 MUKEMII 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAK U 0 2010 Registrar

10-0178	33
Julia A.	Butler

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Julia A. Butler		Sta 1- For State	ate of Maryland / I	•		nd Mental I	Hygiene		0.0001
Physicia		Registrar 1. Decedent's Name (First, Middle	Last)	Certificate o	Deam		2. Date of Dea	eg. No.	3. Time of Death
Medical Examin		Julia A. Bu	tler				Month March 2,	Day Year	1020 hrs
		4a. Facility Name (if not institution Franklin Square Hospit			4b. City, Town, Rosedale	or Location of Dea	th	4c. County of Do Baltimore C	
Funeral				In yrs. last birthday)	If Under 1 Ye	ear If Under 24H	rs. 8. Date of Bi	rth(MM/DD/YYYY) 9.	
Director		219-38-9358	1 M 2 K F	68 Yrs		ays Hours M	12/09	1941 1	reign Country) VC
any	Í	Usual Residence of Decedent 10a. State 10b. County	147	O City Town and age			1007		10d. Inside City Limits
* .		MD TOD COUNTY		Baltimo	vo .				1 Yes 2 No
Maryland 28a-f show d at once.	Director	10e. Street and Number		Commission	10f. Zip Code	,	1	0g. Citizen of What 0	7.
the fifteer	ă		orne Drive		21:	237		USA	
ath wit	Funeral	11. Marital Status 1 Never Married 2 Mar	12. Was Decedent Ev	If Y		Hispanic Origin? (; an, Mexican, Puer		14. Race - Ar White, etc	nerican Indian, Black, c.
ifter death	by Fu	3 Widowed 4 Divo	1 Yes 2	No 1	Yes 2 X	No specify:		Specify:	Black
2 hours afte "oatural" Examioe	뒿	15. Decedent's Education (Speci		during m		pation (Give kind o		16b. Kind of Busine	ss/Industry
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5-0036 ed within 7 tygiene. other thao	탉	17. Father's Name (First, Middle, I	_ast)	Coura	LIVICIOI			Maiden Surname)	Caro
21215-0036 Ald be filed within 7 Mental Hygiene. marked other thace cevent, the Medial	8	Willie Hans				Juli	a Row	e_	
O \(\frac{1}{2} \) \(\frac{1} \) \(\frac{1} \) \(\frac{1}{2} \) \(\frac{1}{2} \	ဍ	Delnora Noble	Daughter		4 17 . 1	eet and Number or		nber, City or Town, St	aryland 21737
ore, ML s: 1 and 2 s of Health au If item 27	ľ	20a. Method of Disposition		20b. Place of Dispos	sition (Name of o		Date	20c. Location City	or Town, State
Pages nent of		Burial 2 Cremation Donation 5 Other Spe		Arbut		3	11/2010	Baltimore	Maryland
Baltimore permit. Pages 1 a Department of Ht Important: If it		21. Swiature of Fune el Service L	11		ame and Addre	ess of Facility	TC 149	105 York RA	4 1 2000
Physician	+	23a. Part I. Enter the disease, or c	complications that caused the	e death. Do not enter t	he mode of dyin	g, such as cardiac	or respiratory arr	est, shock, or heart	Approximate Interval
Examiner		failure. List only one cause of Immediate Cause (Final disease	n each line. a. Hypertensiv	e atheroso	leortic	cardiov	ascular	disease	Between Onset and Death
LAMITIME	-	or condition resulting in death)	Due to (or as a consequ						
	<u>ا</u> ةِ	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequ	ence of):					
	티	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consequ	ence of):					
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transition of the control of the con		IF FEMALE: 3b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of		tal death 3	Ectopic pregr	nancy	23d. Date of deliver Month	very Day Year
eath ce	SICI	1 Yes 2 No 9 ✔ Unkn	4 Pregnant at tim	e of 5 Ot	her (Specify)				
s, P.O. Be ires that the de signed by the		Part II. Other significant condition		ut not resulting in the u	ınderlying cause	given in Part I.	23e. Did to	bacco use contribute	to the cause of death?
Division of Vital Records, P.O. Is a for attending Physician: The law requires that the safe death. The this certificate has been signed by led in by the funeral director, page 2 should be detach.	ğ D	<u>Diabetes mell</u>	litus				1 Yes	2 No 3 F	robably 4 🗹 Unknown
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Vital Rec ysician: The his certificate director, page	8	25. Was case referred to medical examiner?	Hospital: 1 Inpatient	2 ER/Outpatient	_	Other		Residence 6 Ot	har
og Phy iog Phy After th	2	1 Yes 2 No 27. Manner of Death	28a. Date of Injury (Month, Day,Year)	28b. Time of I		jury at Work?		now injury occurred	
Sion Attendi death. ctor: A	igt ggt ggt	1 X Natural 5 Pendir 2 Accident Investi	ng gation			Yes 2 No			
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Hospid 24 hour Funer tely fill		4 Homicide 29a. Certifier (Check only) 1 Certifying Phy	rsician: To the best of my kr	nowledge, death occur	red at the time,	date and place, an	d due to the caus	e(s) and manner as s	tated.
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the		one) 2 Medical Exam	iner:On the basis of examination and manner stated.	ation and/or investigat	ion, in my opinio	on, death occurred	at the time, date	and place, and due to	the cause(s)
	Σ :	29b. Signature and title of certifier				S.M.E.		29d. Date signed (Month, Day, Year)
	Ļ	January January 30. Name and aderess of person w	the completed cause of deat	h (Item 23a)	0.0	·.IVI.C.	0	March 3, 2010	
φ		Pamela E. Southall, MD	•		1 Penn Stree	et, Baltimore,	MD 21201		
Stat	e	31. Male filed (Menth, Day, Year)	32. Registrar's S	Signature	П,				
Registra	.11	- 4010	conserve p.	Sold Charles					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 5 per fh g901 3-9-10 vt
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death WARRU Physician/ 208AM Carrol1 Walter Brown 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death County of Death CLEN BURNIE AMME MASHINGTON MPIDICAL 111 ENTER If Under 24 Hrs. Social Security Number 220–18–7460 Age (In yrs. last birthday) If Under 1 Year Months Days 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 XM 2 1 Hours Min 06/05/1928 81 Director Usual Residence of Decedent shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 28a-f 1 Yes 2 X No MD Anne Arundel Glen Burnie 5 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 512 Milton Avenue 21061 U.S.A items death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian the Medical Examiner Black, White, etc. 0 1 Never Married 2 Married Completed by 1 ☒ Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. "natural", 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done of life. DO NOT use retired) (Specify only highest grade completed) during most of working and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Auto Industry Automotive Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, I once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) BROWN, CARROL ည Carroll Brown Helen Klaunberg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Sylvonia G. Brown / wife 512 Milton Avenue, Glen Burnie, Maryland 21061 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 🗆 Burial 2 🖾 Cremation 3 🗀 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 03/05/2010 Glen Burnie, Maryland tlantic Crematory 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 1 2nd Ave, SW Glen Burnie, MD Singleton Funeral & Cremation Services, Part 1. After the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or a subsection of the cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ me TIP disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): sician and burial-transit Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) the 9 Unknown detached 9 Unknown Division of Vital Records, P.O. signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of 24a, Was an has autopsy performed death? certificate 2 🗌 No 1 Yes Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 🗹 Inpatient 2 🗆 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work' Accident 1 🗌 Yes 2 🗌 No Investigation filled in by the Suicide 6 Could not be 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. npleted Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated the only one 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. title of 29b. Signat certifier

State Registrar 30. Name and address of person who comp

Year)

5 2010

31. Date filed (Month, Day, Ye

pital.

Glen Burnie mi) 20161

eted cause of death (Item 23a) (Type, Print)

. Registrar's Sign

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Please Type or Print in BlacksIndelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene For State Registrar 1-Certificate of Death Reg. No./ 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 20^{Year}0 Ruth Beam March 9:37 AM /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 4111 C Baker Lane Nottingham Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1 □ M 2 X Months Days Min. Hours 212-50-0189 Yrs Director 62 April 13,1947 Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show traumatic event, the Medical Examiner must be notified at MD Director 1X Yes 2 □ No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with Funeral 703 Berry Street or items 23a 21211 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify white Š 3 ₩idowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7.
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "ne any injury or other traumatic event. In a sone. Elementary/Secondary (0-12) College (1-4or 5+) At Home Homemaker 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Russell Kingery, Sr ပ္ Catherine Ivy Tracey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 1 2 3 6 19a. Informant's Name/Relationship (Type. Print) Linda Kates-daughter 4111 C. Baker Lane-Nottingham, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place)
Dulaney Valley
Memorial Gardens 20a. Method of Disposition 20c. Location - City or Town, State by Burial 2 ☐ Cremation 3 ☐ Removal from State Timonium, Maryland Mar.7, 2010 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 10 Evans Funeral Chapel and Cremation Services 8800 Harford Road-Parkville, Maryland 21234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** YEAR >MALL disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Physician/Medical Examine Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 🔀NX certificate has been signed by the rector, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division of Vital Records, 23e. Did tobacco use contribute to the cause of death? é 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ¥ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 □ No 1 ☐ Yes 2**X_X**00 1 ☐Yes funeral director 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Expecity} \) \(\text{Daughter's} \) 1 ☐ Yes 2√2√No this Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) Residence 28b. Time of After 28d. Describe how injury occurred 1 X Natural 5 ☐ Pending investigation death. To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu 1 ☐Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 🗌 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) LUIS PIAZ, MD March 3, 2010

State Registrar 9LTIMORE,

21287

Name and address of person who completed cause of death (Item 23a) (Type, Print)

55.

CRBI

egistrar's Signature

DRUEAUS

Qar) Q5

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Eleanor C. Bondurant A_{\bullet}^{M} 2010 7:56 March /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Towson Manor Care - Ruxton Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year December 10, 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days 1 □ M 25 XF 83 Yrs. 219-22-6205 Balt., Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 23a or 28a-f show event, the Medical Examiner must be notified at Baltimore Maryland 1 ☐ Yes 2 No Towson 10f. Zip Code 10g. Citizen of What Country? United States 10e. Street and Number 21204 1041 Kenilworth Drive of America Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? or Items 11. Marital Status 1 □ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married white Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo Specify: ģ 3XXWidowed 4 ☐ Divorced natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) medical secretary permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: If item 27 Is marked other i any Injury or other traumatic event, III 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary O. Fischbach Leland S. Snell ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type. Print) 3452 Keswick Road Baltimore, Maryland 21211 Mr. Keith L. Bondurant/ son 20b. Place of Disposition (Name of cametery, cremator) or other place)
Dulaney Valley
Memorial Gardens 20c. Location - City or Town, State 20a. Method of Disposition Date March 6, 1 Nation 2 ☐ Cremation 3 ☐ Removal from State Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2010 21. Signature of Funeral Service License 22. Name and Address of Facility
Peaceful Alternatives Funeral & Cremation Center, P.A. 2325 York Road Timonium, Maryland 21093 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) disease Cosonam **Physician** /Medical Due to (or as a consequence of): Examiner heery Congestive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ELGOLO LASEN/ON physician and s the burial-trans Due to (or as a consequence of): Physician/Medical Hyper attending pl 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) Ö 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Huperlividemia Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed certificate 1 ☐ Yes 2 ☐ No Vital 1 ☐Yes 2/1 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 42 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 2 o o the Hospital or Attending Pl ithin 24 hours after death. o the Funeral Director: After th ompletely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 1/X Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical completely and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 0 03-02-10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NOEWOT ZV OSLEY SYIYE J. HIRVARA MS 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ .201<u>0</u> Hester Brafa March 01 10:15 P.M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore County Pickersgill Retirement Community Towson 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth Funeral 1 □ M 2 F July 11 1923 Frakes, Kentucky Director 403-22-9367 86 Usual Residence of Decedent 28a-f show within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director must be notified Maryland Baltimore County Towson 1 Yes 2 XNo 0 10e. Street and Numbe 10f. Zip Code 10g Citizen of What Country? 23a Funeral 615 Chestnut Ave. 21204 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 0 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify 3 Widowed 4 Divorced Specify: White "natural" Completed Year or Dates Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the Payroll Banking 12 N/A of the and Mental Hygie 27 is marked other if traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Sherman Jones Tisha Partin t. Page 1 and 2 should b tment of Health and Mer rtant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Nancy Winegard (Daughter) 14 Ivy Reach Court Cockeysville, Maryland 21030 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State March 04, permit. Page 1
Department of I
Important: If its
any injury or or 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State Druid Ridge Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2010 Reisterstown, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Peaceful Alternatives Funeral & Cremation Center, P.A.
2325 York Road Timonium, Maryland 21093 Jeffrey L. Gair, Sr. e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Par 1. Enter the disease, or compli-shock, or heart failure. List only one Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death 04 Physician/ Complications Denuka Medical resulting In death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter onderlying Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Day Year the detached 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>중</u> should be Division of Vital Records, Hospital or Attending Physician: The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? has page 2 autopsy performed? Yes 2 No certificate within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 X No Other: 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending 1 Tes 2 No Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifiei Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 3 💢 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) CRNP R149194 March 2, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1 G701 N. Charles Marian Grant Towson. 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		for State	State of Marylar				lental Hy	giene	2010	00001
		Registrar		Cer	tificate of L	Death		Reg. No.	2010	1 10021
Physic Med		Decedent's Name (First, Middle, Last Maria)	But1	er		2. Date of Dea Feb 26		LO Year	3. Time of Death 3:05 P M
Exam		4a. Facility Name (if not institution, give s	street and number)		4b. City, Town, or	Location of Death			County of Dea	
1		Pineview Nursi			Clinton				Prince	George's
Funera Directo		579 22 6589 1	x 7. Age (<i>In yrs. I</i> 93	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day Aug 15	h y, Ye <i>ar)</i> , 191	g. Bir L6 Ma	thplace (State or Foreign untry) ryland
ind show at	'n	Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	ation					10d. Inside City Limits
//aryla 8a-f s tified	ect	MD P.G.		Cli	nton					1 🗆 Yes 2 No
the had a or 2		10e. Street and Number			10f. Zip Code		Т	10g. Citiz	en of What Co	ountry?
th with ms 23	Funeral Director	9106 Pineview I			2073			Unit	ed Sta	tes
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Fu	11. Marital Status 1 □ Never Married 2 □ Married 3 ▼ Widowed 4 □ Divorced	12. Was Decedent Ever in U.9 Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give XX Year or Dates.	li		ispanic Origin? (Spe n, Mexican, Puerto Specify:			4. Race - Ame Black, Whit pecify:	
5-00 hours	lete	15. Decedent's Ed	ucation	16a. Deced	ent's Usual Occupa	ation		16b. Kind	d of Business	
215 lin 72 le. han ",	l E	(Specify only highest grade Elementary/Seconday (0-12)	de completed) College (1-4 or 5+)	life. Do	NOT use retired)	luring most of worki	ing			,
d with lygien her the	Be	12		Hou	sekeeper				sekeepe	r
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental hygiene. Important: If item 27 is marked other than "natural", on any highy or other traumatic event, the Medical Exampne.	일 명	17. Father's Name (First, Middle, Last) John F. Bryan	nt			18. Mother's Name Alice		Maiden Su	ırname)	
aryl		19a. Informant's Name/Relationship (Type		19h Mailin	a Address (Street a	and Number or Rura		City or To	own State 7	Codel
M 2 st alth a n 27 is		Brenda Bryant (Ni	iece)			y Road, U				
of He H item		20a. Method of Disposition 1XXBurial 2 Cremation 3		Place of Dispo	sition (Name of natory or other plac	e) [Date	20c. Loca	ation - City or	Town, State
Lim Page Ement tant: Jury o		4 Donation 5 Other (Specify,) Ha	rmony	Memorial	Park 3/5				Maryland
Bal permit Depar Impor any in		21. Signatur f Funeral Sentice Ligense	Z moo257	22	Name and Addres	ia Ferry	Funera Road, C	1 Hom linto	ne, Inc on, MD	. 6633 01d 20735
		23a. Part 1. Enter the disease, or compl shock, or heart failure. List only on	lications that caused the deat	h. Do not ente	r the mode of dying	g, such as cardiac o	r respiratory arr	est,		Approximate Interval Between
Physician		Immediate Cause (Final disease or condition		1munar	y Failure	2			9	Onset and Death
Medica Examine	-	resulting in death)	Due to (or as a consequ	,						
	ē	Sequentially list conditions, if any, leading to immediate	b. Hyperten Due to (or as a consequ							
ansit	Examiner	cause. Enter Underlying Cause (Disease or iinjury	Diabetes		tus					
760 Ke cate be executed physician and sthe burial-transit		that initiated events resulting in death) Last	Due to (or as a consequ							
60 ate be hysici	edical		d							
687 ertifica ding p	₩	IF FEMALE:	3c. If yes, outcome of pregna	nev						-
Division of Vital Records, P.O. Box 68760 (4) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	1 Live Birth 2 Feta 4 Pregnant at time of c	ıldeath 3 ⊑	Ectopic pregnancy Other (specify)	У		23	3d. Date of del Month	ivery Day Year
hat the ed by detac		Part II. Other significant conditions con	ntributing to death but not res	ulting in the u	nderlying cause give	en in Part I.	23e. Did to	bacco use	contribute to	the cause of death?
IS, I	ed by	Dementia					1 □ Y	res 2 💢	No 3□Pi	robably 4 🗆 Unknown
w req	Completed						24a. Was a		24b. Were aut	topsy findings available
Rec The la ate ha	e C						autop perfor 1 \(\sum \) Yes	med?	death?	completion of cause of
tal	Be (25. Was case referred to medical examiner?			26. Pla	ice of Death (Check		ZALINO		
f Vi Physic this o	은	1 Yes 2 X No	ospital:			4 A Nursing Ho	me 5 Reside	ence 6	Other (Speci	fy)
no ding I th. After funer	Certificate:	1 X Natural 5 ☐ Pending	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury work? M 1 🔲	at ? Yes 2 \(\sum No	28d. Describe ho	ow injury o	occurred	
Sio	ij	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho	me, farm, stre			28f. Location (St	treet and N	Number or Rui	al Route Number,
Divi		4 🗆 Hornicide determined	building, etc. (Specify,)			City or Towr		Variable 07 7127	ai riodio rvairiboi,
ne Hospi n 24 hou ne Funer pleted fill	Medical	(Check 2 Medical Examin	cian: To the best of my knowler: On the basis of examination Practioner: To the best of my	and/or investi	gation, in my opinio	n, death occurred at	the time, date an	nd place, ar	nd due to the c	ause(s) and manner stated.
To the	-	29b. Signature and Vitle of certifie			29c. License D-515	number	2	29d, Date s	signed (Month	
^		30. Name and address of person who co	mpleted cause of death (Item	23a) (Type. Pr		N -		_ ~	- &	0,0,0
2		Bahram Pishdad,			,	, Suite 3	10, Was	hingt	ton, DO	20032
Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signat		6					
Regist	oood GI	MAR 0 5 2010	Several S. A	Barke						

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 06622 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Raymond Edward Boulay, Sr. March 2010 1:45 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Timonium Baltimore 6. Sex 1 X M 2 F 5. Social Security Number **Funeral** Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 92 Davs Hours Min March 30 215-05-8608 Director Maryland 191 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location death with the Maryland Examiner must be notified at Director 10d. Inside City Limits Baltimore or 28a-f Maryland Towson 1 🗆 Yes 2 🕅 No 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must be Funeral 520 Chestnut Ave. 21204 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White, etc. Yes 2 X No þ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 🏋 No Specify. If Yes, Give Completed 3 Widowed 4 Divorced Specify. white Year or Dates 15 Decedent's Education Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 manufacturing representative manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Raymond Joseph Boulay Josie Millicent Peters 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Boulay/wife 520 Chestnut Ave. Towson, MD 21204 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 XX Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) Maria Cemetery Mar. 8,2010 Towson. Marvland 21. Signature of Funeral Service License Mitchell-Wiedefeld Funeral Home, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) **CONGESTIVE HEART FAILURE** Medical Due to (or as a consequence of Examiner Sequentially list conditions. Examine if any, leading to immediate Due to (or as a consequence of): Cause (Disease or linjury ysician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) physician Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Li Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Dav 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Yes tor: After this certificate has been the funeral director, page 2 shoul Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 2 **X** No 2 No Yes 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 🗶 No Other: မ 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 Tes 2 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Hospital or Attending Physician: The law requires that the 24 hours after deat Funeral Director: completed To the within 2 To the I

> State Registrar

(Check

30. Name and add

JONES,

only one 29b. Signature and title

DHMH 17 Rev 7/2009

2300 DULANEY VALLEY RD.

ess of person who completed cause of death (Item 23a) (Type, Print)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

TIMONIUM, MD 21093

29d. Date signed (Month, Day, Year)

2010

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 6:00 AM HARRY PRESTON BOLLIN 03 2016 60 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner BALTIMORE N/A GOOD SAMARITAN HOSPITAL If Under 1 Year | If Under 24 Hrs._ Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) SEPT 15, 1917 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1 X M 2 □ F MD 92 215-07-2725 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show ed other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at 1 ▼Yes 2 No Director BALTIMORE MD N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21206 5447 WHITWOOD RD Funeral 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married WHITE land 21215-0036 1 ☐Yes 2 🛣No If Yes, Give Year or Dates Specify: Completed by Specify 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) MACHINE OPERATOR DATRY 8TH 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mental pe Health and Menta em 27 is marked SADIE SELMA JOHN BOLLIN Pages 1 and 2 should ၉ or other traumatic Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5447 WHITWOOD RD BALTIMORE, MD 21206 permit. Pages 1 and 2 s Department of Health an Important: If Item 27 Is any injury or other trau ELSIE BOLLIN-WIFE Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 3/5/10 BALTIMORE, MD PARKWOOD CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility MILLER-DIPPEL FUNERAL HOME, INC 21. Signature of Juneral Service Licensee 6415 BELAIR RD BALTIMORE, MD 21206 23a. Pht1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Fina **Physician** SEPSIS disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner PHEMONIA Sequentially list conditions, if any, leading to immediate cause. Liner Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner OBSTRUCTIVE PULMONARY DISEASA HRONEC burial-trar Due to (or as a consequence of) attending physician for use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
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2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

To the Hospital or Attending Physiclan: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, ieral Director: A within 24 hours a

HARRY

State

SATISH 31. Date filed (Month, Day, Year) MAR 0 5 2010

29b. Signature and title of certifier

KABRA 5601, LOCH PAVEN BOULEVARD BALTIMORE, MD-21239 32. Registrar's Signatur

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RES-000

29d. Date signed (Month, Day, Year)

03/02/2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND ITEM#19b, perFH, G901, 3/8/2010, WS State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** DORIS ANN CLAXTON 11:15 AM MAR 2010 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner CARROLL RINGE OVERLOOK N.H WESTMINSTER If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🔀 F 90 Yrs. 510 5407 16 1920 KANSAS Director FEB 12 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 1 ☐Yes 2 No CARROLL Director MO WESTMINSTER 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 3816 RINGE ROAD 21157 USA Be Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married "natural", or 1 ☐ Yes 2 XNo Specify: Baltimore, Maryland 21215-0036 WHITE 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) U.S. GOU'T SECRETARY 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) WESLEY Williams CLARA MENTZER ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) JACQUELYN HOB ENGLISH SELF COUNT ELDERSBURG, MC 104 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12010 WINFIELD, MO South CARROIL CREM 21. Signature of Funeral Service Licensee 22. Name and Address of Facility IN ZUMBMN FH & MON G 23a. Part Lenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 6028 SYKESUILLE RD ELDENSBURG MO 2178 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Alzheimer's D. 58456 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? Completed by Division or Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 2/No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 ☐ Yes 2 No Certification: To 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 Accident 1 TYes investigation within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide KC Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier H53939 2010 on Des 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) , Do ; 218 Washington Haights Med Ctr; westminiter Imancel

DHMH 17 Rev 1/2001

Registra

31. Date filed (Month, Day, Year)

MAR 0 5 2010

barker

32. Registrar's Signature

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** CANADA Year MARTE CONSTANCE 8:20 PM MARCH 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPITAL HAR BOR BALTI MORE If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 □ M 2√2 F 216-68-4267 55 Director 12-12-1954 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 106 County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at Director 1 Yes 2 □ No N/A MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 2 2450 Wilgrey Ct Funeral 21230 U.S.A. items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married or, Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: Black Specify ò 3 Widowed 4 Divorced 'natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8th Grade Janitorial Janitorial Co is marked other permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othe any Injury or other traumatic event ODE. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Tomas Jones ဂ Norine Canada 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of **Joseph**20b. Place of Disposition (Name of **Joseph**20c. Location - City or Town, State
30c. Location - City or Town, State
40c. Location Tracey Phillips(Daughter) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Joseph H. Brown Jr. Funeral Home 2140 N. Fulton Ave., BAltimore, MD 23a. Part 1. Ther the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death namediat: Cause (Final dis use or condition resulting in death) Physician SEPSIS THREE DAYS /Medical Due to (or as a consequence of). Examiner RIGHT BUTTOCK CUBITUS ULLER Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy for in the past 12 months? 1 □Yes 2 □ No Month Day Year 5 Other (specify) the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ACRUIRED IMMUNO DEFICIENCY SYNDROME 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? CHRONIC OBSTRUCTIVE PULMONARY 24a. Was an autopsy performed? certificate 1 ☐ Yes 2 No 2 No funeral director. Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 ☐ Homicide 1 MacCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ADUSUMILLI MD RES 000 MARCH 2 2010 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SESHA ADUS HANOVER STREET BALTIMORE, MD, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 0 5 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Maryland	•	artment of I tificate of I			giene Reg. No.20	10	06626				
	Physicia Medic		1. Decedent's Name (First, Middle, Last)	James Steph	en Ca	asamassi	na	2. Date of De Month	Day	Year 010	3. Time of Death 10:04				
	Examin		4a. Facility Name (if not institution, give stre	et and number)		4b. City, Town, o	r Location of Death		4c. Count	y of Death					
1			3127 A Wallford I	rive			ında1k		Ва	ltimo:	re				
ı	Funeral Director		146-60-69/8	7. Age (In yrs. la	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Oct.	th y, Year) 5 1959	Coun	olace (State or Foreign stry) W. York				
	ld now at	ا ـ	Usual Residence of Decedent 10a, State 10b, County	10c City	. Town or Loc	cation				1	10d. Inside City Limits				
	arylar a-fst fied	Director	,	imore	, , , , , , , , , , , , , , , , , , , ,		da1k				1 🗆 Yes 2 іXNo				
	or 28		10e. Street and Number			10f. Zip Code		1	10g. Citizen of	What Cour	ntry?				
	with t	Funeral	3127 A Wallford	Drive			21222		-	ed Sta					
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	<u>.</u>		Was Decedent Ever in U.S	13. Was Decedent of Hispanic Origin? (Specify Yes or No				14. Rad	ce - Americ	can Indian,				
336		Completed by I	1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 X Yes 2 No If Yes, Give Year or Dates.		If Yes, specify Cuban, Mexican, Puerto Rican, e 1 ☐ Yes 2 🏋 No Specify:			Bla Specify	nck, White, o	white				
9	hours natur lical I	lete	15. Decedent's Educa	ition	16a. Decedent's Usual Occupation				16b. Kind of E						
215	(Specify only highest grade completed) [Give kind of work done during most of working life. DO NOT use retired) [Give kind of work done during most of working life. DO NOT use retired)							7.		.)					
21	Disabled N/A														
gue	e filec tal H ed otl even	To Be	17. Father's Name (First, Middle, Last)				18. Mother's Nar			ie)					
2	uld b d Mer mark natic	-	Vito Casamassin		T		·	hy Roug							
Ma	2 sho th and 27 is 1 traur		19a. Informant's Name/Relationship (Type, Mary A. Casamassin	•			and Number or Ru lford Dri		-		222				
ā,	and Heal tem (20a. Method of Disposition	20b. Pl	ace of Dispo	sition (Name of	1	Date	20c. Location						
J0	ent of ent of nt: If i		1 ☐ Burial 2 ☑ Cremation 3 ☐ Read Cremation 5 ☐ Other (Spacify)	noval nom state	-	natory or other pla	ce) Corp. 3/4	/2010	Tows	on M	aryland				
Baltimore, Maryland 21215-0036	mit. Pa partme portan / injury		21. Signature Fundal Service Lizense												
1 7922 Wise Ave. Dundalk.									. Marvi	and	21222				
			23a. Part 1. Enter the disease, of confolications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Applications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interest.												
-4	hysician		Immediate Cause (Final disease or condition	OBSTRUCT	IVE	SLEEP!	APNEA				Onset and Death				
	Medical Examiner		resulting in death)	Due to (or as a consequence CHRONIC	ence of):	CTIVE P	ULMONARY	DISE	45E		UNKNOWN				
1		ner	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequ						$\overline{}$					
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9	cate be executed physician and the burial-transit	dical	d .							_					
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×	ath ce attenc for us	ian	in the past 12 months?	1 Live Birth 2 Fetal	death 3	death 3 Ectopic pregnancy				ate of delive onth	ery Day Year				
Ď.	the ched	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown		_ out of (openity) _									
P.O. Box 687	requires that the death certific been signed by the attending should be detached for use as	y Pi	Part II. Other significant conditions contri	buting to death but not resu	ulting in the u	inderlying cause g	iven in Part I.	23e. Did t	obacco use con	tribute to th	he cause of death?				
S,	luires en sign uld be	ed t	BITOLAK	DISORDER				1 🗹	Yes 2 ☐ No	3 Pro	bably 4 □ Unknown				
Division of Vital Records,	iw red is bee 2 shoi	Completed by						24a. Was		Were auto	psy findings available empletion of cause of				
Rec	The law cate has page 2 s	Som						perfe	ormed?	death?					
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Ξ	hysic this or al dire	၉	1 🗌 Yes 2 🖾 No	pital:			4 ☐ Nursing F	lome 5 4 Resi)				
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siol	death ctor: y the	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	28e. Place of Injury - At ho	me. farm. str		ies Z 🗆 NO	28f. Location 6	Street and Numb	per or Rura	I Route Number.				
įΞ̈́	after Direction by	Ö	4 Homicide determined	building, etc. (Specify)		,,,		City or Tov		707 07 71474	, riodio riamos,				
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier 1 Certifying Physicia (Check 2 Medical Examiner	n: To the best of my knowle	edge, death of	occured at the time	e, date and place, a	and due to the ca	luse(s) and man	ner as state	ed.				
	the I-	Me	only one) 3 Certifying Nurse P	ractioner: To the best of my		death occurred at the	he time, date and pla		e cause(s) and m	nanner as st	tated.				
	og wit		29b. Signature and title of certifier	MD		29c. Licens	00 6 00 27	.	29d. Date signe	RCH	3 2010				
	•		30. Name and address of person who com	pleted cause of death (Item	23a) (Type 5										
			LORRIN PAVID M	ARTIN 5200	EASTE	RN AVEN	LE MFL-	5-WEST	BALTIM	iore p	HECCLE DUPTAN				
П	Stat Registra		31. Date filed (Month, Day, Year)	32 Registrar's Signat	1. 10	alled									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** Paul Barry Carver 4:45 2010 March /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Towson

If Under 1 Year | 1f Under 24 Hrs. | 8. Date of Birth

Months | Days | Hours | Min. | A pril 1 Day (Month) Baltimore Greater Baltimore Medical Center 9. Birthplace (State or Foreign Country) North Caro 7. Age (In yrs. last b **Funeral** 1**X** M 2 □ F 65 Carolin 220-40-7915 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show Item 27 is marked other than "natural", or items 23a or 28a-f shot other traumatic event, I'm Medical Examinar must be notified at Westminster Maryland Carroll 1 ☐ Yes 2 ☐No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1605 Auburn Ct. 21157 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Yes 2 V If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 2 3 Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Baltimore County and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Driver Fire Dept. 18. Mother's Name (First, Middle, Maiden Surname) Maryland 17. Father's Name (First, Middle, Last) should be Joseph Hardy Carver Wilma Orna Hodges ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s 1605 Auburn Ct. Westminster, MD. Beverly Carver - wife Department of Heal Important: If Item 2 any Injury or other once. Itimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) March 8, 2010 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Finksburg, MD. Evergreen Mem. Gardens permit. 22. Name and Address of Facility Eckhardt Funeral 21. Signature of Funeral Service Licensee Chapel P.A. Hart Eishandto 3296 Charmil Dr. Manchester, 21102 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between set and Death Immediate Cause (Final 500515 **Physician** Threedays disease or condition resulting in death) /Medical Due to (or s a consequence of): Examiner neumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner spital or Attending Physician: The law requires that the death certificate be executed ours after death.

erral Director: After this certificate has been signed by the attending physician and filled in by the funerial director, page 2 should be detached for use as the burial-transit uansuscell anungea 5 resulting in death) Last Due to (or as a cobsequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 1 □Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only on examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28b. Time of 28a. Date of Injury 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural (Month, Day, Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide within 24 hours a 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2D Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M n n 9 hall A. Levine 65 69 North Cl 6569 31. Date filed (Month, Day, Year) 32. Registrar's Signature MAR 05

Registrar

29c. License number

Charles Street

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 1254 a.M 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** epruary 24,2010 /Medical 4a. Facility Name (If not institution, give street and number, 4c. County of Death 4b City, Town, or Location of Death Examiner General Hospital eti more rary land If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Date of Birth (Month, Day 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours Days 1 ☐ M 2 💢 F Director Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 28a-f show ortant: If Item 27 is marked other than "natural", or Items 23a or 28a-f shov injury or other traumatic event, the Medical Examinations and inside at 1 Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number #1205 by Funeral Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items amy injury or other traumatic event, the Medical Examination once. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) mem 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Be 1 ပ a 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Son lowwood Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other (5 3 ☐ Removal from State 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signatur of Juneral Service Licensee oseph Home 23a. Part 1. Inter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** IROSEPSI'S /Medical Due to (or as a consequence of): **Examiner** Farlure. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of. Examine Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 3 🗆 Ectopic pregnancy Month Year 5 ☐ Other (specify) sate has been signed by the page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Donknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe within 24 hours after death.

To the Funeral Director; After this certificate I completely filled in by the funeral director, pagr 2 No 1 □Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner?
1 ☑ Yes 2 ☐ No 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 27, Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28h. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide t 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated the 29d. Date signed (Month, Day, Year) 29b. Signature and title of gertifier 29c. License number 0 Name and address of person who completed cause of death (Item 239) (Type, Print RA Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

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Millie	Collins

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ 0110 hrs **Medical Examiner** March 2, 2010 (if not institution, give street and number) 4h. City. Town, or Location of Death 4c. County of Death Baltimore Sinai Hospital If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** Days Hours Months Director 213-36-2037 Usual Residence of Decedent 2X F 20-М 10d. Inside City Limits iny 10b. Count 10c. City, Town or Location s 23a or 28a-f show a notified at once. 1 Yes 2 No permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyggiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f who. Director 10g. Citizen of What Country? Funeral 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No. 11 Marital Status 12. Was Decedent Ever in U.S. , or items Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married 2 Married Yes Specify: Black 3 Widowed 4 Divorced If Yes. Give Year Yes 2 No specify: the Medical Examiner ≥ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Stodia Be 19b. Mailing Address od of Disposition 20b. Place of Disposition (Name of cemetery, Baltimore, 2 Cremation 3 Removal from State Other Specify Signature of Fun Physician /Medical disease, or complications that caused the death. Do not ente etween Onset and failure. List only one cause on each line Death a Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last attending physician and or use as the burial - transi Physician/Medical AMENDED UNPENDED 68760 23d. Date of deliver 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Year Fetal death Month Day 2 past 12 months? Pregnant at time of death Box Other (Specify) that the death 1 Yes 2 V No 9 Unknown Unknown the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ö ð 1 Yes 2 No 3 Probably 4 Unknown σ, Diabetes Mellitus; Chronic Obstructive Pulmonary Disease; Congestive Heart Failure Completed Records. 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of The law I certificate has performed? death? 1 ✓ Yes 2 No 2 No 1 🗸 Yes 26.Place of Death (Check only one) 25. Was case referred to medical Be of Vital Hospital: Other | Nursing Home 5 Residence 6 Other 2 V ER/Outpatient 3 DOA this Inpatient ✓ Yes 28a. Date of Injury After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 V Natural 1 Yes 2 No Pendina the Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be Suicide Homicide

Fo the Hospital or Attending Physician: Division within 24 hours after death To the Funeral Director:

29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. March 2, 2010 luleeM

30. Name and address of person who completed cause of death (Item 23a)

111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Laron Locke MD. 31. Date filed (Month: Day) 32. Registrar's Signature

State Registrar

Medical

OCME

ORIGINAL

DHMH 17 Rev 1/2001 **OCME 2006**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician 2:18 Morch 2010 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number, Examiner BALTIMORE ST. HGNES 409PITAC 7. Age (In yrs. last birthday) 74 Yrs. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 6. Sex **Funeral** Months Days Hours 1 □ M 2 🗸 F OCT30, 1935 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygene. Important: If item 27 is marked other than "natural" ~ " any injury or other traumatic every". 10d. Inside City Limits 10c. City, Town or Location 1 ☐ Yes 2 No lumbia toward Director 10g. Citizen of What Country? 10f. Zip Code Apt. 10e. Street and Number USA Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 Mo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐No Specify: þ 3 ☐ Widowed 4 X Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired). Conlege (1-4or 5+) Elementary/Secondary (0-12) lechnologis 17. Fath is Name (First, Middle, Last) Be homas me 1ea ပ (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19b. Mailing Address ormant's Name/Relationship (Type. Print) Columbia 20b. Place of Disposition (Name of 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ F 3 Removal from State Da Breene Fineral Services 21. Signatur of Funeral Service License. 23a. Part1. Enter no disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) days Physician /Medical **Examiner** Single of the conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence oi) Examiner The law requires that the death certificate be executed detached for use as the burial-transi been signed by the attending physician and should be detached for use as the busic to the Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in they underlying gause given in Part I. Completed by 3 Probably 4 Unknown 1 □ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☑ Yes 2 ☐ No 24a. Was an autopsy performed After this certificate or Vital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Medical Certification: To Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manuar of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation Division 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD D0004964 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ST. AGUES LOSPITAL BACTIMORE, HB 21229 KIKED, M.D. 32. Registrar's Signature 31. Date filed (Month, Day, Year) 5 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Vear Month 10:55A[™] Crawford 28 Sheila Cook Feb. 2010 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours 1□M 2X F 579-64-9083 9. Ohio 61 Jan 1949 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 X Yes 2 □ No Washington, 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20002 1218 Girard Street, NE USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 2 College (1-4or 5+) Elementary/Secondary (0-12) US Park Police Guard 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) George ALexander Crawford Ruby Mae Hanes 19b Mailing Address (Street and Number of Rural Route Number, City of Town, State, Zip Code) 5807 Cherrywood Terrace #103 Greenbelt, MD 20770 19a. Informant's Name/Relationship (Type. Print) Kevin Cook/Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Chesapeake Crematory 3/15/10 Beltsville, MD 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Austin Royster Funeral Home 21. Signature of Funeral Service Liceuse 3821 14th Street, NW, Washington, DC 20011 M00996 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immedi te Cause (Final disease or condition resulting in death) ACUTE MYOCARDIAL INFARCTION Due to (or as a consequence of): DISEASE CORONARY ARTER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 C Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? HEART FALLURG 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🎇 Unknown KIDNEY DISENTE 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy 2 - No 1 ☐ Yes

Physician) /Medical **Examiner**

Physician

/Medical

Examiner

10a. State

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Director

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Director

Funeral

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r than "natural", or items 23a or 28a-f shorthe Medical Expression to a stilled at

72 hours after

permit. Pages 1 and 2 should be filed win Department of Health and Mental Hygien Important: If Item 27 is marked other the any injury or other traumatic constitutions.

Maryland 21215-0036

Baltimore,

Box 68760,

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Records,

of Vital

Division

Examine executed and the burialcertificate be as asn

attending physician o been signed by the should be detached has page 2 certificate

the Hospital or Attending Physician: this certific After this funeral of after death Director: A

Physician/Medical 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 🖾 No 9 Unknown ģ CONGESTIVE Completed CHROWIC 25. Was case referred to medical examiner? Be Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 1 Anatural 5 Pending investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier 000 pu 29c. License number 0324 29d. Date signed (Month, Day, Year) MARCH 1, 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
TOPHE, MD, FACTP, 7600 C CARROLL AVENUE, THROMA PARK, MAPULAN

State Registrar

Medical

31. Date filed (Month, Day, Year)



in 24 hours the Funeral Dire

within 2

completely

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Katherine Cosgrove Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington County Hospital Hagerstown Washington **Funeral** Social Security Number 7. Age (In vrs. last birthday, If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, 1 □ M 2 💢 F Pennsylvania Months Days Hours Director 217-32-5796 75 Jan Usual Residence of Decedent 28a-f show 10a. State the Medical Examiner must be notified at 10c, City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No MD Washington Hagerstown 10e. Street and Number 10f. Zip Code items 23a or 10g. Citizen of What Country? Funeral 750 Dual Highway 21740 USA Was Decedent of Hispanic Ongin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?...
1 Yes 2 No Black, White, etc. δ 1 Never Married 2 Married 'natural", or Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 □ Divorced Completed White Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 73 Department of Health and Mential Hyglene. Important. If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 6th Homemaker Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ John Lightner Katherine Straitiff 19a. Informant's Name/Relationship (Type, Print) No. Mailing Address (Street and Number or Rural Route Number, City or Jown, State, Zip Code)
1029 W. Washington Street, #12A
Hagerstown, MD 21740 Hagerstown, Paul Cosgrove/Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Howard University Jan 27,2010 Washington, DC ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Austin Royster Funeral Home 3821 14th Street, NW, Washington, DC 20011 M00996 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, k, or heart failure. List only one cause on each line. Interval Between Onset and Death mediate Cause (Final Physician/ isease or condition Cerebo Varaen Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death.

the Funeral Director: After this certificate has been signed by the attending physician and the burial-transi Cause (Disease or in that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 5 Other (specify) Day Pregnant at time of death Month 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 \(\subseteq \text{ Yes} \) 2 \(\subseteq \text{ No} \) autopsy ~ Dunn 2 46 **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Tyes Other: 2 No ၉ 1 Enpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director: A

completed filled in by the f Accident Investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) alt mo D18019 JAN 28, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 21740 MILL ST MAKERSTOWN VASAVT DATTA ~0 340 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ MARCH ROBERT WILLIAM CALLAHAN 2010 3:59 A Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Stella Maris Hospice Timonium Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min. (Month, Day, Yea Country)
Maryland 1X M 2 - F Months Days Hours Director 219-34-6791 69 1940 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location should be filed within 72 hours after death with the Maryland iral", or items 23a or 28a-f sho Examiner must be notified at Director 1 Yes 2X No Florida Charlotte Punta Gorda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 215 Rio Villa Drive 33950 #3184 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black White etc. 1 Never Married 2 X Married 1 ★Yes 2 No If Yes, Give Year or Dates. "natural", or Completed by Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Department of Health and Mental Hygiene. Important: If item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12 Facilities Manager Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည any injury or other traumatic once. Thomas Neil Callahan Emma Grace Mohr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Callahan / Wife permit. Page 1 and 2 337 Spry Island Road, Joppa, MD 21085 Baltimore, 20a. Methodrof Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 □ Burial 2 ☑ Cremation 3 □ Remarks 4 □ Donation 日 □ Other (Specify) 4 Donation Other (Specify) Hilltop Service Corp.: 3-4-10 Towson, Maryland I Se 21. Sign tere of Fu ice Li McComas Funeral Home, P.A. 1317 Cokesbury Road, Abinadon. MD 21009 23a. Part 1. Enter the disease, or complica that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ PANCREATIC CANCER disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to for as a consequence on attending physician and for use as the burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Day Other (specify) Pregnant at time of death signed by the a 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 🔲 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed ROBERT 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an s certificate has the autopsy performed? Yes 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE 2 🗶 No ဂ္ 1 Yes nours after death.

neral Director: After this c
if filled in by the funeral dire 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral L Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of 29c. License numbe 29d. Date signed (Month, Day, Year) 2010

201

Registrar

TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

of person who completed cause of death (Item 23a) (Type, Print)

/Medical Examiner burial-tran requires that the death certificate be exect Division of Vital Records, P.O. Box 68760. To the Hospital or Attending Physician: The within 24 hours after death

To the Funeral Director:
completely filled in by the

Physician

/Medical

Examiner

Director

Funeral

Completed

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death with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examination at a notified at

Physician

Baltimore, Maryland 21215-0036

hysician/	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ■ No 9 □ Unknown		pic pregnancy er (specify)	-	23d. Date of delivery Month Day Year
ted by Pr	Part II. Other significant conditions of	contributing to death but not resulting in the underly	ing cause given in Part I.		o use contribute to the cause of death? 2 No 3 Probably 4 Unknown
Complet				24a. Was an autopsy performed:	
e	25. Was case referred to medical		26. Place of De	ath (Check only one)	
0	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 [DOA Other: 4 Nursing H	dome 5 Residence	6 ☐ Other (Specify)
rtification:	27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year) n 28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	jury occurred
Certifica	3 Suicide 6 Could not by determined		octory, office	28f. Location (Street City or Town, St	and Number or Rural Route Number, ate)
edical (29a. Certifier (Check only one) 1 ★ Certifying Pr	nysician: To the best of my knowledge, death occuminer: On the basis of examination and/or investig and manner stated.	arred at the time, date and place ation, in my opinion, death occ	e, and due to the cause urred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
Me	29b. Signature and title of certifier		29c. License number	29d.	Date signed (Month, Day, Year)

GREENE

MO

00065557

TREE

BAUTIMUMA MO 21208

State Registrar MARTIN

31. Date filed (Month, Day, Year)

PAI

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ENGALMAROT

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM# 19a, perFH, G901, 3/9/2010, WS

State of Maryland / Department of Health and Mental Hygiene

			1	State Registrar			Ce	ertificate of	Death		Reg. I	No. 2 0	0 06635
	Physic	ian/	1	. Decedent's Name (First, Middle, La	ast)		_			2. Date of Month	Death	Total of	3. Time of Death
	Me	lical	L	Edward Deaton a. Facility Name (if not institution, given				T		02-26			130 A M
9	Exam		ı	Stella Maris				4b. City, Town, c	um		4c. County of Death Baltimore		
	Funer Directo		4	402-28-6897	Sex 1 X M 2 □ F	7. Age (In yrs. 86	last birthday, Yrs.	If Under 1 Year Months Days		Min. 8. Date of 1 0 2 - 1 1	Birth Day Year -192	9. B	irthplace (State or Foreign ountry) KY
	ind show	5		Usual Residence of Decedent Oa. State 10b. County		10c. C	City, Town or L	ocation					10d. Inside City Limits
	Aaryla 8a-f s tified	Director		MD Harfo	rd		Bel A	Air					1 ☐ Yes 2X No
	with the N 23a or 2	Funeral Di	1	Oe. Street and Number 330 Hunters Run				10f. Zip Code 210	15		-	Citizen of What C	Country?
а.m. 036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at	ed by Fun	·	Marital Status Never Married 2 Married Widowed 4 □ Divorced	12. Was Dece Armed For 1 Yes If Yes, Give Year or Da	rces? 2 X No e	J.S. 13	Was Decedent of HIf Yes, specify Cub.	an, Mexican, P	? (Specify Yes or N uerto Rican, etc.)	lo-	14. Race - Am Black, Wh Specify: Wh	ite, etc.
26, 2010 1:20 a. Maryland 21215-0036	iin 72 hour e. han "natu	Completed	-	15. Decedent's (Specify only highest of Elementary/Seconday (0-12)	Education		(Give	edent's Usual Occup e kind of work done DO NOT use retired,	during most of	working	4	Kind of Busines	-
21	y with ygien her th	Be C		12			Own	er			C	entury 1	Neon Sign Co.
2010 yland 2	ld be filed Mental H arked ot atic ever	ToB		7. Father's Name (First, Middle, Last, William H. Deato					18. Mother's Addie	Name (First, Midd Stacy	le, Maide	n Surname)	
	nd 2 shou ealth and m 27 is m			9a. Informant's Nan <mark>je/R</mark> elationship (Carolyn II. DeSha		hter)	19b. Mai 170.	ling Address (Street Berdan	and Number of Ct Be 1	r Rural Route Num Air, MD	ber, City 210	or Town, State, 2 15	(ip Code)
FEBRUARY Baltimore	Page 1 a ment of H tant: If ite jury or oth		2	0a. Method of Disposition 1 Burial 2 Cremation 3 Donation 5 Other (Spec		State	cemetery, cre ighviev	osition (Name of ematory or other pla Mem. Ga	r. 03	Date 3-01-2010	Fa	Location - City $\mathfrak c$	MD
FEB	permit Depart Import any inj	500	2	Signature of Funeral Service Licer	nsee		2	22. Name and Addre	ess of Facility S • MacPh	Schimunek Mail Rd B	Fun elAi	eral Hor r MD 210	ne of BelAir 014
,,,	Physiciar	į		23a. Part 1. Enter the disease, or cor shock, or heart failure. List only mmediate Cause (Final disease or condition	one cause on ead	ch line.	ath. Do not en	ter the mode of dyir	ng, such as car	diac or respiratory	arrest,		Approximate Interval Between Onset and Death
9	Medica Examine			esulting in death)		or as a consec	quence of):						
	uted d ansit	Examiner		Sequentially list conditions, fany, leading to immediate cause. Enter Underlying Cause Usease or injury hat initiated events	b. — Due to (c	or as a consec	quence of):						
0	cate be executed physician and the burial-transit	Medical Ex		resulting in death) Last		or as a consec	quence of):						
8760	tificate ng phi as th	Med	-	FEMALE:			-						
0 X 6	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transi	Physician/		in the past 12 months? 1 Yes 2 No 9 Unknown		Birth 2 □ Fe nant at time of	tal death 3	☐ Ectopic pregnand ☐ Other (specify) _	су		-	23d. Date of d Month	elivery Day Year
	requires that the des been signed by the s should be detached		ľ	art II. Other significant conditions END STAGE DEMENT		eath but not re	sulting in the	underlying cause gi	ven in Part I.				to the cause of death? Probably 4 🗆 Unknown
EDWARD D of Vital Records,	The law recate has be page 2 sho	Completed by								l pe	as an topsy rformed? s 2 X I	prior to death?	utopsy findings available completion of cause of
草	cian: certific ector,	Be	2	5. Was case referred to medical examiner?	Hospital:					Check only one)			-
Ž	Physic this cral dir	은	2	1 Yes 2 X No 7. Manner of Death	1 🗆 I		ER/Outpatie	ent 3 DOA Oth	4 U Nursir				cify) HOSPICE
ion o	ital or Attending us after death. ral Director: After	Certificate:		1 X Natural 5 ☐ Pending 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not	(Monti	h, Day, Year)	injury	M 1 🗆	yat ⟨? Yes 2 □ No				
Division	oftal or Attenums after deat oral Director:			4 Homicide determined	buildin	ig, etc. (Specif	fy) 	reet, factory, office		City or To	own, Stat	'e)	ural Route Number,
5 8	To the Hospital or Attending Physician: The k within 24 hours after death. To the Funeral Director: After this certificate h completed filled in by the funeral director, page	Medical		only one) 3 A Certifying Nu	niner: On the basi	s of examination	on and/or inve	stigation, in my opinio death occurred at the	on, death occur e time, date and	red at the time date	e and place the cause	ce, and due to the e(s) and manner a	cause(s) and manner stated s stated.
	D With		2	3b. Signature and title of certifier	2 CRN	P		29c. Licens	e number 9797		29d. D	ate signed (Mon	th, Day, Year)
			3	D. Name and address of person who				Print) LLEY RD.	TIMON	IUM, MD 2	21093	3	
ľ	St Regis	ate rar	3	. Date filed (Month, Day, Year) MAR U 5 201	/32. Re								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Genevieve S. DelCiello 2010 :48P February Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Balto. 5168 Brightleaf Court Rosedale Social Security Numbe 7. Age (In yrs, last birthday) 1 Year If Under 8. Date of Birth 9. Birthplace (State or Foreign Funeral Months Davs Hours Min (Month, Day, Year) Maryland 63 Director 6,1947 January 220-48-2779 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 shor any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits Director Rosedale 1 Yes 2 No Md. Balto. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21237 USA 5168 Brightleaf Court Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2🏋 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify White Specify: Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Sophia Skira Peter Stinach 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5168 Brightleaf Ct. Rosedale, Md. 21237 Donald J. DelCiello spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 3 - 3 - 2010Balto. Md. Bayview . Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home 9705 Belair Rd. Nottingham, Md. 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a nsequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events and the burial-tran Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 as attending IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death use 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ for in the past 12 mg Month Day Year Pregnant at time of death the detached Unknown 9 Unkrown sate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autonsv perform death? 2 🗌 No 1 🗌 Yes Yes 2 Be 25. Was case referred to medical examiner? the funeral director, 26. Place of Death (Check only one) Hospital: Other ျှ 1 Yes 2. 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death

Natural

Accident 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred DIVISION OF Heading injury work? 1 ☐ Yes 2 ☐ No 5 Pending within 24 hours after death.

To the Funeral Director: A
completed filled in by the fu M Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) (Item 23a) (Type, Print)

State Registrar 32. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #8, per Fh g901 3/24/10 TT
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 23 Day Physician/ AMIANO P.M Cb. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTA SPRING Brook Silver NUrsing PRING 8. Date of Birth 3/18/1922 Stirthplace (State or Foreign (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Social Security Number 188–12–2772 **Funeral** 1 M 2 □ F Months Days Min. 87 Director Usual Residence of Decedent show Director with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Silver Spring MD Montgomery items 23a or 28a-f 1 Yes 2 Xo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12621 Eastbourne Dr. 20904 Funeral filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Race - American Indian. Armed Forces? 1 ☑ Yes 2 ☐ No Black, White, etc. unk. 1 ☐ Never Married 2 ※ Married "natural", or Completed by Baltimore, Maryland 21215-0036 white 1 Yes 2 XXNo Specify: If Yes, Give 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)
FOOD Broker 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) T.C. Howard Food Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Angelo Damiano Susan Tomaine 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
12621 Eastbourne Dr., Silver Spring MD 20904 19a. Informant's Name/Relationship (Type, Print) Mildred J. Damiano 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. Patrick's R.C. Cem. 3/1/2010 20a. Method of Disposition 20c. Location - City or Town, State 1 🗆 Burial 2 🗆 Cremation 💹 Removal from State McAdoo, PA 4 Donation 5 Other (Specify) 22. Name and Address of Facility Charles L. 5+CVCNS 21. Signature of Juneral Service Lice Ren AVENUE BALLO MARYLAND21230 FORT 23a. Part 1. Enter the dis as- or o shock, or heart failure. List o cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Cardiac Arrythmia Physician/ disease or condition instant Medical resulting in death) Due to (or as a consequence of) **Examiner** Hypertension 10 yrs Supportion like and tions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of) 5 yrs Chronic Renal Insufficiency attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 9 Unknown ned by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò advanced dementia, thyroid disorder Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 A N 2 🔀 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 🗆 Yes 2XXNo 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 I ER/Outpatient 3 I DOA after death. Director: After this 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work? 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town. State! within 24 hours a To the Funeral D Medical 1 🔲 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29c. License number R096053 CRNP 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2/24/2010 30. Name and address of person who impleted cause of death (Item 23a) (Type, Print)
Babette Pennay, CRNP, 15245 Shady Grov 15245 Shady Grove RD # 130 Rockville MD 20850 31. Date filed (Month, Day, Year) 32. Registrar's Signatur State

DHMH 17 Rev 7/2009

Registrar

MAR U 5 2010

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State of Maryland / Department of Health and Mental Hygiene

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		1- For State Registrar		Certific	ate of	Death			 F	Reg. No.	<u>~</u> U	. 0	
Physicia	n/	1. Decedent's Name (First, Midd							Date of Dea		Year		3. Time of Death
Medical Examir	ier	Michael	Lee		_	rich	-1	1	March 2,	2010			1718 hrs
		4a. Facility Name (if not institution 34 Shipway	on, give street and number)	40	. City, Town, c Dundalk	or Location	of Death			: County o		nty
Funeral		5. Social Security Number	6. Sex 7. Ag	ge (In yrs. last bir	thday)	If Under 1 Ye	ar If Und	er 24Hrs.	B. Date of B	irth(MM/l	DD/YYYY)		nplace (State or
Director		216-04-7692	1X M 2 F	26	Yrs.	Months Da	ys Hour	s Min.	August	21.1	983	Foreigr Cou	n ^{Intry)} Maryland
	ŀ	Usual Residence of Decedent							1 209000	2.7	300		
w any		10a. State 10b. County		10c. City, Town								- 1	10d. Inside City Limits
Maryland 28a-f show 1 at once.	ģ	Maryland Bal	timore	<u></u>		ndalk				40 0'''			1 Yes 2 No
e Mar or 28s	Director	34 Shipway				10f. Zip Code	1222			Tog. Citiz	zen of Wha USA		try?
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once.		11. Marital Status	12. Was Deceden	t Ever in U.S	13 Was	Decedent of H		gin? (Speci	fy Yes or No	0-			an Indian, Black,
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after o	Ş L	3 Widowed 4 Div	orced If Yes, Give Year or Dates:	[22] 140	1 1	es 2 X N	o s <i>pecify</i> :				Specify:	Whit	te
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MD 21215-003 d 2 should be filed within the and Mental Hygiene. In 27 is marked other the numatic event, the Medianmatic event, the Medianmatic event.	۱٩	19a. Informant's Name/Relations				ddress (Stre							
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Baltimore, permit. Pages I ar Department of Hee important: If iten njury or other tr	-	1 Burial 2 Cremation	3 Removal from St	ate crema	tory or othe	place)		March				-	own, State
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Baltimore, ME permit. Pages 1 and 2 s Department of Health a Important: If item 27 imjury or other traum		21 Signature of Funeral Service	Licensee)	00,,	Con	ne and Address	uner	al Hon	ne Of	Dunc	lalk,	P.A.	21222
Physician	Ť	23a. Part I. Enter the disease, or		the death Do n	ot enter the	0 Solle mode of dying	ers Po , such as c	OINT F ardiac or re	KOACL, spiratory arr	DUNC rest, sho	LALK, ck, or hea	rt TID.	21222 Approximate Interval
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760, cate be ex physician he burial	Medical	IF FEMALE:	23c. If yes, outcor	ne of pregnancy						224	. Date of d	dolivon	
Box 68760, e death certificate be the attending physic of for use as the burner.		23b. Was decedent pregnant in the past 12 months?	e 1 Live birth		Fetal	death 3	Ectopic	c pregnancy			Month	Da	ay Year
Sox 687 leath certifi e attending for use as t	Physician		nown 9 Unknown	time of death	5 Othe	(Specify)				2342			
D. B r the de by the		Part II. Other significant conditi		n but not resultin	g in the und	erlying cause	given in Pa	art I.	23e. Did to	obacco u	ise contrib	ute to th	ne cause of death?
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Vita	e Re	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatie	ent 2 ER/O	utpatient 3		Other ₄	Nursing H		Residen	nce 6 🗸	Other: \$	Scene
Division of Vital Records, rat or Attending Physician: The law requires after death. al Director: After this certificate has been stern by the funeral director, page 2 should the fineral director, page 2 should the funeral director for the funeral dir	=	27. Manner of Death	28a. Date of Inju (Month, Day,Y	ry 28b.	Time of Inju	' '	ry at Work		f. Describe	how injur	y occurred	d	
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit.	رة ق	(Check only	ysician: To the best of moniner: On the basis of exam										
To To Cor	ğ	29b. Signature and title of certifie	and manner stated.			29c, Licens	se number			29d. D	ate signed	1 (Monti	h, Day, Year)
		Mhr. Kin	assell MY			O.C.	M.E.			Marc	ch 3, 20°	10	
	-	30. Name and address of person	who completed cause of d	eath (Item 23a)						<u> </u>			
		Melissa Brassell, MD	Assistant Medical		111 Per	n Street, E	Baltimore	e, MD 212	201				
Sta Registra		31. Date filed (<i>Month, Day,</i> Year) MAR 0 5 201	32. Registra	r's Signature	ake								
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year DONALD LEE DONAHOE AM :40 2010 4a. Facility Name (If not institution, give street and number) 4c. County of Death Cen Ralt eda uare ta If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 UNKNOWN 8. Date of Birth (Month Day Year)
MAY 28, 1937 Social Security Number 6. Sex V. Age (In yrs. last birthday) Days 1√2 M 2□ F 220-36-1254 72 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State Yes 2□No MD N/A BALTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 404 ELRINO STREET 21224 12. Was Decedent Ever in U.S. Armed Forces? 1▲Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married WHITE 1 □Yes 2X No Specify: Specify. 3 Widowed 4X Divorced 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) 12TH College (1-4or 5+) STEEL WORKER BETHLEHEM STEEL 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) MAE GHEEN RAYMOND DONAHOE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1529 ALDENEY AVE BALTIMORE, MD 21220 19a. Informant's Name/Relationship (Type. Print) GARY DONAHOE-BROTHER 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition IX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) OAKLAWN CEMETERY 3/5/10 BALTIMORE, MD 22. Name and Address of Facility CHARLES S. ZEILER AND SON, INC 21. Signature of Fune al Service Licensee BALTIMORE, MD 21224 6224 EASTERN AVE 23a. Part - Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Scale met Due to (or as a consequence of): Sequentially list conditions Tue to for as a consucuence of: cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 □Yes 2 □No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performed 1 ☐ Yes 2 **N**o 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Man r of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 112 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only

Hospital or Attending Physician: The law requires that the death certificate be execute P.O. Box 68760, for Division of Vital Records, page 2 s funeral death. nours after death,
neral Director; /
filled in by the fi

Physician

Examiner

Funeral

Director

r than "natural", or items 23a or 28a-f show the intedical Evaluation must be notified at

is marked other

27

permit. Pages 1 and 3 Department of Health Important: If item 27 any injury or other tr once.

Physician

/Medical

Examiner

Donothole Donadd Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

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Examiner

Physician/Medical

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Completed

Be

Medical Certification: To

29b. Signature and title of certifier

/Medical

within 24 hours a completely +1

State Registrar

30. Name and address of person who completed cause of death (Item

and manner stated

90000

29c. License number

29d. Date signed (Month, Day, Year)

Baltimore

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death 15 - 3 2 M . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Elizabeth Ellis MONTH 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Union Memorial Hospital Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 09-18-25 1 □ M 2X□XF Months Days Hours Min. Country) 84 Director 212-26-2162 NC Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits should be filed within 72 hours after death with the Maryland Examiner must be notified at Director MD NA 1 X Yes 2 No Baltimore 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 1100 Pennsylvania Avenue Apt. 21216 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. African Completed by 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: Specify:American 3 X Widowed 4 Divorced Year or Dates event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Zion Tower Senior Elementary/Seconday (0-12) College (1-4 or 5+) 11th Grade Receptionist Building Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked o မ Horton Jack Commie Horton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $\overline{21216}$ and l 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Helen M. Ricks-Daughter 834 N. Bentalou Street Apt.#1 Baltimore,MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State Western Star Cem. 03-08-10 |Baltimore, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Wylie Funeral Home P.A. 638 Ν. Street Baltimore Gilmor MD23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ anoxic encephalopathy 3 W 65 disease or condition Medical resulting in death) Examiner nypo tension Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence or) the attending physician and ned for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d Date of delivery in the past 12 months? Month 2 No 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? age revol clusterse Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Vescular disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Sepsis performed Yes 2 2 🗹 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Other: 뎯 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural 28a. Date of injury 28b. Time of 28c. Injury at Certificate: (Month, Day, Year) work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident Investigation completed filled in by the Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours after of Funeral Direct determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I lown 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Union Memorial Hospital. Baltmare, MD

State Registrar

32. Registra Signature

foun

			State of Maryland / Dep	artment of Health and M		- 2 1 T 1 1 1	06641							
			1 - State Registrar Ce 1. Decedent's Name (First, Middle, Last)	rtificate of Death	Reg. t	10.								
	Physicia		Harold Eldridge		2. Date of Death Month March	Day Year	3. Time of Death 2:22P M							
	Medic Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4	c. County of Deatl	1/4							
No. or or	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Baltimore Cit		9. Birt	hplace (State or Foreign							
	Director		217-82-2131 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Months Days Hours Min.	8. Date of Birth (Month, Day, Year	757 Con	intry) Maylard							
	land show dat	tor	10a. State 10b. County 10c. City, Town or Lo	ocation Relliance			10d. Inside City Limits							
	e Mary r 28a-f notifie	Direc	Mayland N/T 10e. Street and Number	Baltimore 10f. Zip Code	La		1 Yes 2 No							
	with the s 23a o	Completed by Funeral Director	3326 Garrison Blvd.	21216	10g. (Citizen of What Co	Intry?							
	r death or item	y Fun		Was Decedent of Hispanic Origin? (Sper If Yes, specify Cuban, Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - Amer Black, White								
21215-0036	e filed within 72 hours after death with the Maryland tal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	d pa	3 Widowed 4 Divorced Year or Dates.		Specify: BI	ack								
15-(72 hou In "nat Medica	nple	(Specify only highest grade completed) (Give	edent's Usual Occupation kind of work done during most of workir DO NOT use retired)	ng I	Kind of Business I								
212	ad within Hygiene. other tha	Be Co	College (1-4 or 5+)	Carpenter		Private	<u> </u>							
Maryland		To B	17. Father's Name (First, Middle, Last) Rodger Eldn'dge	18. Mother's Name	(First, Middle, Maide	n Surname)								
Aary	should and M is mai raumat		19a. Informant's Name/Relationship (Type, Print)	ing Address (Street and Number or Rural	Route Number, City	or Town, State, Zip	Code) 21202							
	and 2 Health tem 27		Teeya Eldridge-daughter 125 20a. Methodor Disposition 20b. Place of Disp			Maryl Location - City or								
Baltimore,	mit. Page 1 bartment of bortant: If it injury or c		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, cree 4 ☐ Donation 5 ☐ Other (Specify)	Cemetery 3/8	7/10 BO	Himore	Maryland							
Ball	permit Depart Import any inj once.		21. Signature of Funeral Service Licensee Park 2	2. Name and Address of Facility	Kan Fune	ray Hor	Maryland							
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,														
	Pnysician/ Medical		shock, or heart failure. List only one cause on each line. Interval Be Onset and disease or condition resulting in death) a. Due to (or as a consequence of):											
	Examiner		Sequentially list conditions, b. Endocarditis				Imonth							
	ed sit	Examiner	if any, leading to immediate cause. Enter underlying Cause (Disease or injury)				10 years							
	e be executed ysician and e burial-transit		that initiated events resulting in death) Last C. Due to (or as a consequence of):											
200	cate be physici the bu	edical	d											
P.O. Box 6876	requires that the death certificate been signed by the attending phy should be detached for use as the	Physician/Med	IF FEMALE: 23b. Mss decedent pregnant 23c. If yes, outcome of pregnancy 1	☐ Ectopic pregnancy		23d. Date of deli	very							
. Bo	the att	iysici		Other (specify)		Month	Day Year							
P.0	that th		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco	use contribute to	the cause of death?							
rds,	equires een sig hould b	eted	acute renal failure				obably 4 Unknown							
eco	ne law i te has b age 2 s	Completed by			24a. Was an autopsy performed?	prior to death?	opsy findings available ompletion of cause of							
tal F	cian: Ti ertifical ector, p		25. Was case referred to medical examiner?	26. Place of Death (Check	1 L Yes 2 M2 only one)	No 1 ⊔ Yes	2 No							
of Vi	Physic rr this ceral dire	유	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie 27. Manner of Death 28a. Date of injury 28b. Time o		ne 5 Residence		fy)							
ion	tending eath. or Afte the fund	Certificate:	1 ☑ Natural 5 ☐ Pending (Month, Day, Year) injury 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be	work? M 1 ☐ Yes 2 ☐ No										
Division of Vital Records,	lor Att a erd Direct d⊪ by		4 Homicide determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	reet, factory, office	28f. Location (Street a City or Town, Sta		al Route Number,							
	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours at er death. To the Funeral Director After this certificate has been signed by the attending phy completed filled in by the funeral director, page 2 should be detached for use as the	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death (Check 2 Medical Examiner: On the basis of examination and/or invest	stigation, in my opinion, death occurred at t	the time, date and pla	ce, and due to the c	ause(s) and manner stated.							
	To the within 2 comple	Ĭ	only one) 3 Certifying Nurse Practioner: To the best of my knowledge, 29b. Signature and title of certifier	death occurred at the time, date and place 29c. License number	e, and due to the cause	e(s) and manner as so the signed (Month)	stated.							
	2 pl		> That Caleston MD	Res-000	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	March	1,2010							
~	X		30. Name and address of person who completed cause of death (Item 23a) (Type, Marc Caliatan, MD Simi	Haspital of	Baltim	ore.								
Į.	Stat Registra		31. Date filed (Month, Day Year) 32. Registrar's Signature	base a	.,,,,,,									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#2perPHYS, G901, 3/10/2010 WS
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death Month 26 1. Decedent's Name (First, Middle, Last) 3. Time of Death Gretchen Carter Ennis Physician/ 10:45а м Feb-Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 1910 County Road Apt T-4 Prince George's District Heights 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Maryland 1 M 2 L Months Days Hours Min. (Month, Day, Y Director 20 9706 May 6. 1°9′13 Usual Residence of Deceden: or 28a-f show notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 XNo Maryland Prince George's District Heights 10e. Street and Number ō 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene.
Important: If item 27: is marked other than "natural", or items 23a or amy inlury or other traumatic event, the Medical Examiner must be. Funeral 1910 County Road Apt T-4 20747 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 XXNo If Yes, Give ģ Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: White XX Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Candy Maker Candv Maker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ೭ Robert Carter Swepta Phillanger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ralph Ennis (Son) 13418 Lord Dunbore Place, Upper Marlboro, MD 20772 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) MD Veterans Cemetery 3/15/2010 Cheltenham, Maryland 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old 21. Signature of Juner Alexandria Ferry Road, Clinton, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician. ATTERISCEPTIC andio Caralan 54 disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to in reduct cause. Enter Underlying Examine Directo for as a nonsectionea of attending physician and I for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day ed by the a 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. cate has been signed page 2 should be det 23e. Did tobacco use contribute to the cause of death? 2 Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform Yes 2 death? certificate 1 🗌 Yes 2 No eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) æ examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 🗓 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural
Accident
Suicide 5 Pending within 24 hours after death.

To the Funeral Director: A
completed filled in by the fu 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 085365 30. Name and address of persop who completed cause of death (Item 23a) (Type, Print) (170 / living (for RU #101, ff Crast M. 2 anons State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February FREELAND 2010 6: 13p CONSTANCE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Annapolis Anne Arundel Hospital . Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Funeral Country) DC Hours Year) 941 579-52-5156 68 Director Oct. Usual Residence of Decedent show 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 Yes 2x No Prince Georges Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20772 USA 10708 Wyld Drive 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Bace - American Indian. Armed Forces?
1 ☐ Yes 2 ☒ No Black, White, etc. à 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: "natural", Black Completed 3 X Widowed 4 Divorced Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b, Kind of Business Industry (Specify only highest grade completed) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Executive Secretary 12th Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy, Important: If item 27 is marked oth any injury or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Lossie Jacobs Joe Benton, Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Upper Marlboro, MD. 20772 Erika Lynn Freeland-Daughter 10704 Phillips Dr. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Lincoln Cemetery 3-4-2010 Brentwood, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Marshall's Funeral Home of Maryland 4308 Suitland Rd. Suitland, MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as carding or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examine Due to (or as a conse guence of Cause (Disease or linjury death certificate be executed nding physician and use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No ģ Month Other (specify) Pregnant at time of death the a a I Ilnknown 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No Division of Vital Records, 1 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has page 2 autopsy certificate Yes 2 25. Was case referred to medical examiner?

1 Yes 2 No director, 26. Place of Death (Check only one) Be Hospital: မ Mnpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred 28c. Injury at After 1 Natural iniury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check

Hospital or Attending Physician: The law requires To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: At completed filled in by the fu

> n who completed cause of death (Item 23a) (Type, Print) 31. Date filed (A Registrar's Signatur State 5 2010 Registrar

only one) 29b. Signature and title

30. Name and address of pe

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Day, Year

0

2

Division or Vital Records, P.O. Box 68760,

To the

State Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

			Please	Type or Print AMEND TITES State of Mary	in Black L 1#4c, perf land / Dep	n delible in HYS, G901 artment of I	k. Ensure Al 37572010 Health and M	Copies A WS ental Hygie	ire Legible . ne			
		•	State Registrar			rtificate of l			No.2010	06645		
	Physicia Medic			Granroth				2. Date of Death Month	Day /2 Year	3. Time of Death		
	Examir	ier	4a. Facility Name (if not institution, give s WAS HING TON		TST	4b. City, Town, o	r Location of Death UA PARK	, MD	4c. County of Deat	-Montgomery		
Ī	Funeral Director		5 Social Security Number 6 Social		yrs. last birthday) 68 Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day, Ye	. 9. Bir	thplace (State or Foreign untry)		
		'n	Usual Residence of Decedent 10a, State 10b. County	10	c. City, Town or Lo	cation		10112-1		10d. Inside City Limits		
	Marylar 28a-f sh otified	Director	MN Anoka		Fric					¥⊠ Yes 2 □ No		
	s 23a or 3	Funeral Di	10e. Street and Number 1601 N. Innsbrud	ck Drive		10f. Zip Code	55432	10g	. Citizen of What Co US			
9036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	≲	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🏌 Divorced	12. Was Decedent Ever Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates.		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2X No	lispanic Origin? (Spec an, Mexican, Puerto R o Specify:	ify Yes or No- lican, etc.)	14. Race - Ame Black, White Specify:			
21215-0036	should be filed within 72 hours after and Mental Hygtene. 'is marked other than "natural", 'aumatic event, the Medical Exan	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Seconday (0-12)		(Give	dent's Usual Occup kind of work done OO NOT use retired) Secretar	during most of working	g 16	b. Kind of Business Lega			
Maryland 2	I be filed w fental Hygi rked othe tic event,	To Be	17. Father's Name (First, Middle, Last) Edwin Granroth	den Surname)								
	and 2 should Health and N tem 27 is ma tther trauma		19a. Informant's Name/Relationship (Type Matt Ruby / Son	oe, Print)	19b. Maili 53	ng Address (Street 23rd Av	and Number or Rural enue, Minr	Route Number, Cit neapolis	y or Town, State, Zip MN 55418			
Baltimore,	permit. Page 1 a Department of H Important: If itel any injury or ott		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 🔀 4 ☐ Donation 5 ☐ Other (Specify	Removal from State		matory or other place e Cemeter	y 2/22	2/2010	c. Location - City or Minneapol	is, MN		
Bal	permit Depar Impor any in once.		21. Signature of Funeral Service License	Victor P.	Doda,Jr	ss of Facility L. Stevens ort Ave.	Funeral Baltimor	Home, In	8.			
	Physician/		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	lications that caused the						Approximate Interval Between Onset and Death		
	Medical Examiner		Due to (or as a consequence oi):									
	uted Id ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last b. Due to (or as a consequence of): The professional consequence of the professional consequence									
09	ite be executed hysician and he burial-transi											
. Box 68760	Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Luneral birector, After this certificate has been signed by the attending physician and ated filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ★No 9 □ Unknown	23c. If yes, outcome of p 1 Live Birth 2 4 Pregnant at tim 9 Unknown	Fetal death 3	☐ Ectopic pregnand ☐ Other (specify) _	су		23d. Date of de Month	livery Day Year		
ls, P.O.	requires that the by been signed by should be detact		Part II. Other significant conditions co	ntributing to death but n	ot resulting in the u	underlying cause gi	ven in Part I.			the cause of death?		
ecord!	The law requicate has been page 2 shou	Completed by	11.		<u></u>			24a. Was an autopsy performed	prior to death?	ntopsy findings available completion of cause of		
tal	sician: The certificate I rector, pag	Be	25. Was case referred to medical examiner?	lospital:			lace of Death (Check		- Hoj			
λV	Physi rthis o eral din	<u>ن</u> 1	1 ☐ Yes 2 ☐ No ☐ Parth	1 Vinpatient 28a. Date of injury	2 ER/Outpatie		4 ☐ Nursing Hon	ne 5 Residence 8d. Describe how i	e 6 COther (Special Course)	cify)		
Division of Vital Records,	or Attending F after death. Director: After in by the funer	Certificate:	1 Natural 5 ☐ Pending 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	(Month, Day, Ye 28e. Place of Injury - building, etc. (S)	At home, farm, str	M 1 □	k? Yes 2 \Begin{align*} No		t and Number or Ru	ral Route Number,		
<u>۵</u>		Medical	(Check 2 L Medical Examin	ician: To the best of my ler: On the basis of exam e Practioner: To the best	ination and/or inves	stigation, in my opini	on, death occurred at t	he time, date and p	lace, and due to the	cause(s) and manner stated.		
17	To the I within 2 To the I comple	_	29b. Signature and title of certifier			29c. Licens			Date signed (Monta			
	*		30. Name and address of person who co		(Item 23a) (Type, I	Print)	065929	1 7) /	712/10	2085 ²		
	Sta	te.	31. Date Med (Morn R. V. Year)	MANUC 15	245 5 Signature	hedy (brown Key	Koch	MIH /TH	1 C000		
	Registr		MAK U 5 2010	Teneral of	but	1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2^{Day} VIOLET MARCH 2010 PEARL GALL 9:40 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HARFORD FOREST HILL HEALTH & REHAB CENTER FOREST HILL Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days (Month, Day, Year) 06/10/1923 Country) Maryland Hours Min 1 ☐ M 2X Director <u>219–18–1958</u> 86 Usual Residence of Deceden permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Harford Forest Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 909 Bernadette Drive 21050 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black. White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Completed 3 X Widowed 4 Divorced Specify: White 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Own Home Homemaking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည William Griffith Margaret Griffith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George G. Gall 909 Bernadette Drive - Forest Hill, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith Cem; 03/06/2010 | Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. W مه 11750 Belair Road - Kingsville, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Prosician Engl STa disease or condition resulting in death) Due to (or as a consequence Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to for as a consequence on attending physician and for use as the burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Day Year To the Funeral Director: After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law performed' 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred Natural 5 Pending Accident Investigation within 24 hours after deati To the Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical 29a. Certifie 🕵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 032295 MOTEN 2, 2010 1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAVID DUNN W. MACPHAIL ROAD 615

DHMH 17 Rev 7/2000

Registrar

31. Date filed (Month, Day, Year) MAR 0 5 2010

32. Registrar Signat

21014

BEL AIR, MD.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 25,2010 February Doris Jane Holten 9:20A М 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Keswick Nursing Center Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April20,1920 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Yrs 516-18-8516 89 Montana Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 ☐ Yes 2 No Md. Balto. Nottingham 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 9414 Perglen Rd. 21236 IISA Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 24 If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1∐Yes 2∐XNo White Specify: 3 Widowed 4 □ Divorced 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ray R. Tandy Sallie Arthur 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DTR. Judy Gach 9414 Perglen Rd. Nottingham, Md. 21236 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview 2-27-2010 Balto. Md. 22. Name and Address of Facility Schimunek Funeral Home 21. Signature of Funeral Service Licensee Mammon cognine 9705 Belair Rd. Nottingham, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each ine. Immediate Cause (Final disease or condition resulting in death) neumance Due to (or as a conseque accident Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last disease Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy Year Month Day 4☐Pregnant at time of death 5 Other (specify) 9∏Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 □ No 3 ☐ Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy 25. Was case referred o medical examiner? 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA

Physician /Medical Examiner

Physician

Examiner

Director

Funeral

Completed by

Be

၉

Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "I any Injury or other traumatic event, the Med

72 hours after death with

3altimore, Maryland 21215-0036

/Medical

The law requires that the death certificate be executed burial-tran physician the use as for ed by the a signed by t d be detach certificate has been si rector, page 2 should funeral director, After this ↓ hours after death. -uneral Director: A filled in by ō

P.O. Box 68760,

Division or Vital Records,

Physician/Medical þ Completed Be Medical Certification: To

Examiner

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

(Check only one)

2 No 1 Yes 1 🗌 Inpatient 28a. Date of Injury (Month, Day Year) 27. Manner of Death 5 Pending Investigation 6 Could not be determined 1 Natural 2 Accident

28b. Time of 28c. Injury at Work?

1 🗌 Yes 2 🗆 No 28d. Describe how injury occurred

1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

And manner stated.

29b. Signature and tit

29c. License number

29d. Date signed (Month, Pay, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

ompleted cause of death (Item 23a) (Type, Print) 30. Name and address of pe W. MT. ROYAL AUE, BALTIMORE 1600 9

av 31. Date filed

MAR 0 5 2010

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

State

within 24 hours a To the Funeral E pspital

the_

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		for State Registrar	State of Mary		artment of F		d Mental Hy	/giene Reg. No) 0	06648	}
Physicia		1. Decedent's Name (First, Middle, Las	JARI. F	- 2			2. Date of D		Year	3. Time of Death	Λ
/Medic Examin		4a. Facility Name (If not institution, give	street and number)	onte	4b. City, Town, o	r Location of De	eath F	4c. Cou	inty of Death	MONE	
Funeral Director		5. Social Security Number 6. Security Number 112-32-0221	7. Age (In	n yrs. last birthday 81 Yrs.	If Under 1 Year Months Days	If Under 24 H Hours Mi	in. (Month, D	rth lay, Year) 5/1928	Coun	place (State or Foreig htry) yland	חז
aryland show	٦٢	Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town or L					1	0d. Inside City Limits	
with the M a or 28a-f be notifie	Directo	MD N/A 10e. Street and Number			Baltimo 10f. Zip Code			-	of What Coun		
2 should be filed within 72 hours after death with the Maryland is and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show raumatic event, it is Medical Exerctions must be notified at	Completed by Funeral Director	1 W. Conway Str 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates;		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☐ No	201 dispanic Origin? an, Mexican, Pur Specify:	(Specify Yes or Nerto Rican, etc.)	o- 14. I	S.A. Race - Americ Black, White, e	etc.	
d within 72 hou giene. er than "natura fre Medical E		15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12) 12th Grade	ucation de completed) College (1-4or 5+)	(Give	edent's Usual Occup e kind of work done DO NOT use retired	oation during most of w d)	vorking		f Business/Ind		t
ould be filed Mental Hyg iarked othe	To Be C	17. Father's Name (First, Middle, Last) George Pratt				Nann	lame (First, Middle ie Ware	e, Maiden Suri	name)		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is Medical Exerctions must be notified at once.		19a. Informant's Name/Relationship (7 Jeannette Taylo 20a. Method of Disposition 1□ Burial 2 XCremation 3 □ 4□ Donation 5□ Other (Specify	or (Daughte	r) 5911	osition (Name of matory or other place Brown F	ameda,	BAltimo Date /09/10	ore, MD 20c. Location	212 on - City or To	39 wn, State	
permit. P Departm Importar any inju		21. Signature of Funeral Service Licens		\geq 2	2 Name and Addre JOSEPH 2140 N.	ss of Facility H • Bro	wn Jr.	Funer	imore al Hom ore,M	ne	
And the price of t	dical Examiner	3a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock in the at failure. List only one cause on each line. Inm. If e Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. M.									
	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown	Fetal death 3	☐ Ectopic pregnand	sy		23d.	Date of delive	ery Day Year	
tuires that t n signed by ild be detac	ρ	Part II. Other significant conditions co	ontributing to death but no	ot resulting in the u	underlying cause giv	ren in Part I.		tobacco use o		ne cause of death?	'n
sician: The law rer s certificate has bee lirector, page 2 shot	Completed						24a. Wa auto peri 1 □Yes	opsy ormed?	prior to co death?	psy findings available mpletion of cause of	е
ysiciar is certif director	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	2 ☐ ER/Outpatie	ent 3 DOA Oth	er.	Death <i>(Check only</i> g Home 5 ☐ Res		Other (Specia	~ v)	_
ending Ph aath. or: After th he funeral	Certification: To	27. Manner of Death Natural 2 Accident 5 Pending investigation	28a. Date of Injury (Month, Day, Ye	28b. Time (Injury	Wor	ry at k? iYes 2 □ No	28d. Describe	how injury oc	curred		
oltai or Att Jus after de rai Direct		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	building, etc. (S	Specify)			City or To	own, State)		al Route Number,	
n 24 hou	Medical		ysician: To the best of m iner: On the basis of exa and manner stated.	amination and/or i							
Vithii To th	ğ	29b. Signature and title of certifier	7		29c. Licens		,		gned (Month,		
		30. Name and address of person who of	completed cause of death	(Item 23a) (Type	Print)	1236	Bul	T+m	Ch &	MO 2/2	> ~
Stat Registra	te ar	31. Date filed (Month, Day, Year)	32. Registrar's	Signature) 100	111	V /	·· N 4/6	420

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year <u>10:5</u>5 ^{A м} 28, 2010 Richard F. Hutchinson February 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Montgomery 9. Birthplace (State or Foreign Country) Sandy Spring If Under 1 Year | If Under 24 Hrs. Brooke Grove Nursing and Rehab 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days 1 X M 2 □ F October 26, 1920 Washington, D.C. 213-12-1487 89 Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2 X No Maryland Montgomery Rockville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 4721 Iris Street 20853 United States Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 XYes 2 No If Yes, Give Year or Dates: 1 XNever Married 2 ☐ Married 1 □Yes 2 X No Specify: Specify.White WWII 3 Widowed 4 Divorced 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Financial Controller <u>American Red_Cross</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bertrand Hutchinson Katharine Lappin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4721 Iris Street, Rockville, Maryland 20853 Katharine Greenfield/Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) Arlington National Cemetery 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) March 11, 2010 Arlington, Virginia Cemetery 21. Signature of Funeral Service Vicersee 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda—Chevy Chase, Inc. Mart M01530 Houon 7557 Wisconsin Avenue, Bethesda, Maryland 20814 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Squamous disease or condition resulting in death) CELL CARCINOMA MOUNTH MONTHS Due to (or as a consequence of): Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of: Due to (or as a consequence of): If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ▼ Yes 2 No 3 Probably 4 Unknown FAILURE HEART DEMENTIA. CONGESTIVE 24b. Were autopsy findings available prior to completion of cause of death? performed? 1 □Yes 2 No 1 ☐Yes 2 ☐ No 26. Place of Death (Check only one)

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

Funeral

Director

28a-f show

Director

Funeral

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Completed

36

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r than "natural", or items 23a or 28a-f show

"natural", or

12 should be filed w h and Mental Hygie 7 is marked other ti

permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked i any injury or other traumatic ev

Baltimore, Maryland 21215-0036

Box 68760,

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Division of Vital Records,

or Attending Physician:

Hospital

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24 hours a er dea e Funeral Director

within 2.

After this

completely filled in by the funeral

certificate be executed and

Exami

Physician/Medical

ģ

Completed

Certification:

Medical

State Registrar

physician the attending asn 0 the signed by the has certificate

☐Yes 2☐No 9 I Inknown

25. Was case referred to medical examiner? Be 1 ☐ Yes 2 No ၉

27. Manner of Death

1X Natural

2 Accident

3 ☐ Suicide

4 ☐ Homicide

5 Pending investigation

6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined

Hospital:

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work?

28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

154 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number

SCHOOL RD, SANDY SPRING, MD

29b. Signature and title of certifier in swa

33700

MARCH 1, 2010

20860

31. Date filed (Month, Day, Year)

18430 SLADE



DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of Marylan		artmer			Mental H	ygiene Reg. No:		06650	
	Physici /Medic		1. Decedent's Name (First, Middle, La Jerry L. Ha	rtlove					2. Date of D Month March	Day	2010	3. Time of Death 8:45amM	
)	Examir		4a. Facility Name (If not institution, given 358 Dublin Drive			4b. City		Burnie	2	An	ne Arun	del 	
	Funeral Director		5. Social Security Number 219–40–9417 6. S	6ex 7. Age (In yrs. 65	last birthday, Yrs.	Months	n 1 Year Days	Hours Mi		Birth Day Year) B/44	9. Bir	tholace (State or Foreign buntry) MD	
	Aaryland f show	or	Usual Residence of Decedent 10a. State 10b. County MD	N/A	y, Town or L		Balti	more			. 10d. Inside City Limits 1 🗗 es 2 🗆 No		
	with the Page of t	I Direct	10e. Street and Number 1820 Spence	Street		10f. Zi	Code	21230)	10g. Citizen of What Country? USA			
036	init. Pages 1 and 2 should be filed within 72 hours after death with the Maryland entiment of Heatilt and Mental Hygiene. arment of Heatilt and Mental Hygiene. The Maryland of Heatilt and Hygiene. Injury or other treumetic avant, the Marical Examiner must be notified at injury or other treumetic avant, the Marical Examiner must be notified at 18.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? Ar 1 EYes 2 No If Yes, Give Year or Dates: 62-	Was Dece If Yes, spe 1 Yes		spanic Origin? , Mexican, Pur Specify:	(Specify Yes or Nerto Rican, etc.)	No-	14. Race - Ame Black, White Specify:			
	d within 72 ho piene. r than "natur ine Madical"	Completed	15. Decedent's E (Specify only highest gr. Elementary/Secondary (0-12)		(Give	DO NOT L	ork done di	uring most of w	rorking		Kind of Business/Industry Construction		
P	uld be filed Mental Hygi irked other itlc svent, I	To Be C	17. Father's Name (First, Middle, Last) Edward W. Hartlove 18. Mother's Name (First, Middle, Maiden Sur Ivy Whittington										
	and 2 should alth and Men 27 is marke er treumetic		19a. Informant's Name/Relationship (Ronda Lynn Mille	Type, Print) er / Daughter					Rural Route Num en Burnie			Zip Code)	
Baltimore,	Pages 1: nent of He ant: If Iten ury or oth		20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □ 1 □ Donation 5 □ Other (Special Control of Control	Removal from State Cro		matory or	other place	ns Cem	3/9/20		ocation - City or ownsvil	Town, State le Maryland	
Balt	permit. Pages Department of Importent: If It any injury or once.		2 Signature of Funeral Service Lice		> 15				Funera enue, Ba		e, Inc. re MD 2	1230	
	Physician		23a. Pert1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition	E- 0	h. Do not en IG L O	1	Can	, such as card	ac or respiratory	arrest,		Ap roximate Interval Between O set and Death	
	/Medical Examiner		resulting in death)	Due to (or as consect								U	
~	te be executed ysicien and e burial-transit	cal Examiner	if any, leading to immediate cause. Enter Inderlying Cause (Disease or injury that initiated events resulting in death) Last	c									
Box 68	that the death certificat ed by the attending phy detached for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregn. 1 ☐ Live birth 2 ☐ Fete 4 ☐ Pregnant at time of c	ıl death 3[□Ectopic p				-	23d. Date of de Month	livery Day Year	
<u>a</u>	v requires that the obeen signed by the should be detached	b	Part II. Other significant conditions	contributing to death but not res	ulting in the u	underlying	cause give	n in Part I.		d tobacco i		o the cause of death?	
H	The lav ate has page 2	Completed							24a. W au pe 1 ☐ Yes	topsy rformed?	prior to death?	utopsy findings available completion of cause of	
	Physician: The this certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 242 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatie	ent 3⊡ D	OA Othe	F:	eath (Check only)		6 ⊠⊠ther (Spe	Daughters Home	
	nding Physath. r: After this e funeral di		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury		28c. Injury Work		28d. Describ			OIIIG	
The state of the s										Rural Route Number,			
	Hospitel 24 hours a Funerel (etely filled	edical (29a. Certifier Certifying P (Check only one)	hysician: To the best of my knominer: On the basis of examination and manner stated.	owledge, dea ation and/or ii	th occurred	at the tim	e, date and pla inion, death oc	ice, and due to the courred at the time	ne cause(s le, date an) and manner a d place, and du	s stated. e to the cause(s)	
	To the within 2. To the I complet	Me	29b. Signature and title of certifier	Qual in	· D	29	c. License		27	1	te signed (Mon	* '	
•			30. Name an Laddresy of person whi	ompleted caus of death (Ite	23a) (Type	, Print) 🚜	L	01026	1	Mi	AK4	2610 21229	
	S.	10	1011 Gorm 31. Date filed (Month, Day, Year)	Registrar's Sign	ater	A	R	Sol	timer	2 /	MD.	21229	
	Sta Registi		MAR 0 5 201	1 Reale of	100	Roll							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month 3 Year **Physician** 03 2010 2:00 pm /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner VINGTON 8. Date of Birth (Month, Day, yrs, last birthday) Social Security Number 6. Sex **Funeral** 1 □ M 2 1 F Min. Months Days Hours Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural" ~ ... any injury or other traumatic event. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 Yes 2 □ No Director mor 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 85 2/2 606 by Funeral mn 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give/ Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 No Specify: 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ၉ 19a. Informant's Name/Relationship (Type. Print) (daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sel 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or 20a, Method of Disposition 1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State Mount 5 ☐ Other (Specify) 4 □ Donation 22. Name and Address of Facility
2. Seph L. Rus 21. Signature of Fune al Service Licen alle ausses Ave. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Condeovasculor duear Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical the attending p hed for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 Tyes 2 No 9 Unknown 9 Unknown s been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Completed by 1 ☐ Yes 2 🗷 No 3 Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an s certificate has by director, page 2 s autopsy performed? Yes 2 No 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To To the Funeral Director: After this completely filled in by the funeral di 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a 29a. Certifier 1 ☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

State Registrar

29b. Signature and title of certifier

A. AHME(

MAR 05

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

621

32. Registrar's Signature

N

(hu

31. Date filed (Month, Day, Year)

DR

ELLOU

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First Middle Last) 2. Date of Death Physician/ Month 11:10 M Harris -Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince Georges 3703 Walnut Lane Suitland [] . Social Security Number Birthplace (State or Foreign Country)
 Panama If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days 1 □ M 2 🕱 F Hours Aug I8, **1**930 Director 577-56-2937 80 Usual Residence of Decedent 3a or 28a-f show the notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland Director 1 Yes 2 No MD Prince Goerges Suitland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral the Medical Examiner must 3703 Walnut Lane 20746 USA "natural", or items 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify **Black** 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Private Duty yrs Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ Leonard E. Beckford Leanna Perry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 10322 Peric Court Manassas, VA. 20110 William Harris - Son item 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 3-3-2010 Alexandria, VA. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Marshall's Funeral Home of Maryland 4308 Suitland Rd. Suitland, Md. 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Atherosel Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, isacing to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a someoqueries of) attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the bur IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☒ No Month Dav Year Pregnant at time of death Other (specify) Yes 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy performed prior to completion of cause of death? 1 Yes 2 No Yes 2 1 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be 1 Yes Other: 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 K Residence 6 Other (Specify) 28a, Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No M Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office Location (Street and Number or Rural Route Number, determined building, etc. (Specify) City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d Date signed (Month, Day, Year)

State

31. Date filed (Month. Day

2. Registrar's Signatu

30. Name and address of person who completed cause of death (Item 23a) (Type

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 555 am Physician/ someo Medical **Examiner** 4c. County of Death General ortal timore 7. Age (In yrs. last birthday) 80 Yrs. 9. Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. Date of Birth **Funeral** (Month, Pay, Year) 2 Director ms 23a or 28a-f show must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked of wher than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore 1 XYes 2 ☐ No 10e. Street and Number 10g. Citizen of What Country? Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1X Never Married 2 Married 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life, DQ NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) abore Be 18. Mother's Name (First, Middle, Maiden Surnar 17. Father's Name (First, Middle, Last) Hackett Henjamin Franklin 19b. Mailing Address (Street and Number or Rural Route Number, City or 20b. Place of Disposition cemetery, crematory Burial 2 ☐ Cremation 3 ☐ Removal from State ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee NO Baltimore, Manyland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the Approximate shock, or heart failure. List only one cause an each line Immediate Cause (Final monia Physician/ disease or condition resulting in death) Medical lococcus Aureus Examiner Sequentially list conditions. Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Pregnant at time of death 2 🗌 No been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown cate has been ; page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending work? 1 ☐ Yes 2 ☐ No 1 Natural Accident Investigation within 24 hours after deat

To the Funeral Director:
completed filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Robins Roma MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MiD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MARCH 3. 2010 MARY JESSE HARKINS 5:45 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE OAK CREST NURSING HOME BALTIMORE 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. May 16, Year 1915 Marvland 212-20-2343 94 **Director** Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 10a. State with the Maryland at Director r 28a-f s notified 1 🗆 Yes 2 😾 No Maryland Baltimore Baltimore 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or dical Examiner must be r Funeral 8830 Walther Blvd. USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces? Black White etc. ģ 1 Never Married 2 Married 5-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify: 3 ☑ Widowed 4 ☐ Divorced Completed White Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) r than "... the Mr Baltimore, Maryland 2121 Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed with.
Department of Health and Mental Hygiene.
Important: If item 27 is marked other th;
any injury or other traumatic event, the l Public Education Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Muncie (nmn) Osborne Delray (nmn) Graybeal 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathleen Welch / Daughter 1356 East MacPhail Road, Bel Air, MD 21015 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Removal from State Air Memorial Gdn 3-8-10 Bel Air, Maryland 4 ☐ Donation 5 ☐ Other (Specify) ture of Fune al Service Licensee 22 Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. Approximate Interval Betweer Ons t and Death Immediate Cause (Final Physician/ yrs disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list nonditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No for Month Year Pregnant at time of death been signed by the should be detached Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 performed?

Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be examiner? Hospital 2 No 1 🗌 Yes မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident injury work? 1 ☐ Yes 2 ☐ No 5 Pending 24 hours ar er dec th. Funeral Director A M Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number ģ 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) R043580 12010 elyreis CRT 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WALTHER BLUD JUSTINE 833 31. Date filed (Month, Day, Year) State MAR U 5 201 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Elizabeth Elaine Hale 2010 March 3:03 P. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Hospice Center Towson Baltimore County Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex Funeral (Month, Day, Y 1 □ M 2 🏝 F Months Days Hours Baltimore.MD 212-38-1433 70 Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director Maryland Baltimore County Sparks 1 Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1519 Cold Bottom Road 21152 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White 3 Widowed 4 Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Seconday (0-12) College (1-4 or 5+)
N/A and 2 should be filed within Health and Mental Hygiene. Iem 27 is marked other than the Customer Service 27 is marked other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harry A. Hoover, Jr. Dorothy E. Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i other tra Mrs. Tina H. Rosier (Niece) 1513 Cold Bottom Road Sparks, Maryland 21152 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State March 05, permit. Page 1 a Department of H Important: If ite 1 Burial 2 Cremation 3 Removal from State 5 Evans Funeral Chapel injury o 4 ☐ Donation 5 ☐ Other (Specify) 2010 Forest Hill, Maryland 21. Signature of Juneral Service Licensee Robert O. Biedelman 22. Name and Address of Facility
Peaceful Alternatives Funeral & Cremation Center, P.A.
2325 York Road Timonium, Waryland 21093 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Pnysician non tu disease or condition Medical resulting in death) Due to (or as a cors uence of) Examiner Sequentially list conditions, Examine Due to loi as a consequence on if any, leading to immediate cause. Enter Underlying attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Year Month Day 4 ☐ Pregnant at time of death g ☐ Unknown been signed by the sahould be detached 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 🛪 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has t rector, page 2 s autopsy page performed? Yes 2 M No death? 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medica After this certific funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 2 🕅 No ျ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 D Other (Specify) WSDU this (27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Hospital or Attending 1 🔀 Natural injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide neral Director: A Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a

To the Funeral D

completed filled i Medical ECertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number

Registrar

DHMH 17 Rev 7/2009

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State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NE

gistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MARCH 3°, 2010° **JOSEPH** IGNATIUS HUESMAN 5:40A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 0akcrest Baltimore Parkville 9. Birthplace (State or Foreign 1922 ^{Count} Maryland 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Hours **χ**Χ м 2 □ F February |215-12-9486 88 Director Usual Residence of Decedent or 28a-f show notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director 1 ☐ Yes 🏋 🛱 No Maryland Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō "natural", or items 23a o Funeral 21286 417 Donegal Drive USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 IX Xes 2 □ No WW I I
If Yes, Give Black, White, etc þ 1 Never Married XX Married 21215-0036 1 ☐ Yes XX No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates 27 is marked other than "natu traumatic event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) 5+ permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the M any injury or other traumatic event, the M ones. Elementary/Seconday (0-12) Attorney Private Practice Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Maryland 2 Alice Delcher William Huesman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 417 Donegal Drive Towson, Maryland 21286 Suzanne Geraghty Huesman Wife lore. 20a. Method of Disposition
1 ☐ Burial XX Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State GreenMount Crematory MAR 4,2010 | Baltimore, Maryland Baltir 4. □ Donation 5 □ Other (Specify) i nature of Funeral Se , ce Licens 22. Name and Address of F种性 chell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Enter the disease Approximate Immediate Cause (Final erebrovascular ₽nysician/ disease or condition **Medical** resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of) inding physician ause as the burial-Physician/Medical nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Pregnant at time of death ed by the a P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ş Prostate Ca a No 3 Probably 4 Unknown Division of Vital Records, 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? this certificate has al director, page 2: or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: To Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) within 24 hours after death.

To the Funeral Director: After th completed filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) R171944 cchealle 3/3/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MUN 8800 Walther Blvd, Parkville, MD 21234 Harrison CRNP

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? State Registrar Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 10:14 PM 为型 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 12216 Malin Lane Prince George's Bowie 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1**2** M 2 □ F (Month, Day, Year) 11/19/1950 Months Davs Hours Min Pennsylvania 165-42-1084 Director 59 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Examiner must be notified at Director 1 X Yes 2 No MD Prince George's Bowie 10e. Street and Number 10f, Zip Code ō 10g. Citizen of What Country? Funeral items 23a 12216 Malin Lane 20715 U.S.A. nit. Page 1 and 2 should be filed within 72 hours after death variationed the beath and Mental Hygiene.
ortant: If item 27 is marked other than "natural", or items injury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: White 3 Widowed 4 Divorced Completed Year or Dates. 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Satellite Engineer Aerospace Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ည David Irwin TI Dorothy Farrell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cathy Irwin / Wife 12216 Malin Lane, Bowie, Maryland 20715 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 s
Department of IImportant: If ite
any injury or ot
once. cemetery, crematory or other place 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 Other (Specify) Anatomy Gifts Registry 03/04/2010 Hanover, Maryland 21. Signature / Funeral Se ice Licensee 22, Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that coused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between O set and Death Immediate Cause (Final Prysician/ MIS disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death signed by the a d be detached f Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Junknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate ☐ Yes 1 \square Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \(\sum \) Nursing Home 5 \(\mathbb{D}\) Residence 6 \(\sum \) Other (Specify) 1 🗌 Yes 2 No မ ER/Outpatient 3 DOA 1 Inpatient 2 I 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d, Describe how injury occurred 1 Natural 5 Pending work 1 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Pertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie

State Registrar Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month Physician/ veland 50 Jone Jr 2810 Anon Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SECOURS 4> 39/ Himore ta Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9 Bjrthplace (State or Foreign 6. Sex Funeral Days 1 🛛 M 2 □ F Months Hours Month, Day, Director th and Mental Hygiene. ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10b. County 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. 10a. State 10c. City, Town or Location Director 1 Yes 2 No more 10f. Zip Code 10g. Citizen of What Country 10e. Street and Number Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Race - American Indian. Armed Force Black, White, etc. þ 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 Yes 1 Yes 2 X No Specify: If Yes, Give Year or Dates 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) Be 18. Mother's Name (First, Middle, Maiden Sumame) Father's Name (First, Middle, Last) ပ Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau once. 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) en Mount 22. Name and Address of Fality Joseph L. Russ 2222 W. North 21. Signature of Funer I Service Licens nergy Hom de 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ocardia in farction disease or condition resulting in death) Medical Due to or as a consequence of: **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) The law requires that the death certificate be executed the bunal-transit Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical P.O. Box 68760 as IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) Pregnant at time of death signed by the aid be detached for 9 🔲 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 2 🗌 No 3 Probably 4 Unknown 1 Yes Completed should peen Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy After this certificate has performed? Yes 2 No 1 Yes 2 No **Division of Vital** within 24 hours after death.

To the Funeral Director; After this certific completed filled in by the funeral director, 25. Was case referred to medical examiner? Hospital or Attending Physician: 26. Place of Death (Check only one) Be 2 1116 1 🗌 Yes မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? injury Natural 5 Pending Investigation Accident 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 🖳 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) wanish 05 RP

State Registrar 31. Date filed (Month, Day, Year)

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Street

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2000

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month 2 Physician/ 43 15 ohnsor 2010 Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner Baltimare Secours timor e Social Security Number

741 - 44 - 8121 Birthplace (State or Foreign Country) 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) Funeral Min. 1 🗆 M 2 🗹 F Months Davs Hours Many Bay Director Usual Residence of Decedent 10d. Inside City Limits or 28a-f show 10b. County 10c. City, Town or Location 10a. State permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland other traumatic event, the Medical Examiner must be notified at **Funeral Director** 1 Yes 2 No Baltimore 10g. Citizen of What Country? 10e. Street and Number or items 23a Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Year or Dates "natural", 3 Divorced 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' any injury or other traumatic event, the Me Elementary/Seconday (0-12) Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, 19a. Informant's Name/Relationship (Type, 20b. Place of Disposition (Name of cemetery, crematory or other 20c. Location 1 ★ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Signatur Juneral Service Licensee 22. Name and Address of Facility 23a. Part 1/Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Myo cardi disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to for as a consequence of Cause (Disease or iinjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
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3 Suicide 1 Tyes 2 🗌 No within 24 hours after death.

To the Funeral Director: A Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated 3. only one) 29b. Signature and title of certifier D006356 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Registra State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2010 06660 1- For State Certificate of Death Registrar 2. Date of Death 3. Time of Death Physician/ 1. Decedent's Name (First, Middle, Last) Month Day February 27, 2010 1635 hrs Medical Examiner Joseph Luther Kelly, 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Anne Arundel 24 Warehouse Creek Lane Edgewater If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Months Days Hours Min Director January 7,1957 Country) Virginia 230-88-6575 1 X M 2 F 53 Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location in y 10b. County 1 X Yes 2 No or 28a-f show Maryland Anne Arundel Annapolis or items 23a or 28a-f shormust be notified at once. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21401 United States 709 Melrose Street Funeral 14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc 1 Never Married 2 Married Yes 2 X No permit. Pages I and 2 should be filed within 72 hours after to Department of 'Health and Mental Hygnen Propriate: I fiten 27 is marked other than "natural", o Injury or other traumatic event, the Medical Espaniace In injury or other traumatic event, the Medical Espaniace. White 4 X Divorced If Yes, Give Year 1 Yes 2 No specify: Specify: 3 Widowed ģ or Dates 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Department of Health Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 and Human Services 5+Medical Officer 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last Belle Faucette Joseph Luther Kelly, Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5707 Durbin Road, Bethesda, Maryland 20817 Kathleen K. Oberg / Sister 20b. Place of Disposition (Name of cemetery, March 3, 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 2010 Bethesda, Maryland Montgomery Crematorium, Inc. 4 Donation 5 Other Specify. 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. M01305 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 Approximate Interval 23a. Pary / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line (Medica) a. Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. Due to (or as a consequence of) if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit The law requires that the death certificate be executed Physician/Medical attending physician or use as the burial -UNPENDED AMENDED Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. ģ 1 Yes 2 ✓ No 3 Probably 4 Unknown has been s 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? page 2 No certificate ✓ Yes 2 No 1 🗸 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifi 26.Place of Death (Check only one) 25. Was case referred to medical funeral director, Division of Vital Be Hospital: 1 Other Nursing Home 5 Residence 6 🗸 Other: Scene Inpatient 2 ER/Outpatient 3 DOA 1 V Yes 28a. Date of Injury (Month, Day,Year) FOUND: 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Pilot of plane which crashed Certification FOUND: Natural 1 Yes 2 ✓ No Pending the Feb 27, 2010 1625 hrs 2 🗸 Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 6 Could not be Suicide or Town, State) 24 Warehouse Creek Lane, Edgewater, MD determined (Specify) Wooded field Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certific 29d Date signed (Month, Day, Year) 29c. License number O.C.M.E. February 28, 2010 30. Name and address person who completed cause of death (Item 23a) **OCME** Mary G. Ripple MD. **Deputy Chief Medical Examiner** 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day; Year) 32 Registrar's Signate State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Donna Kicklighter February 28. /Medical 2010 7:30 AM 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examine Golden Living Center Hagerstown Washington 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours Months Days Min. 1 □ M 2 🔯 F Director 56 217-66-5525 Dec 26, 1953 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show dical Examiner must be notified at MD 1 ☐ Yes 2 No Washington Director Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 750 Dual Highway 21740 Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene.

ant: If Item 27 Is marked other than "natural", or items 23a ray or other traumatic event, the Medical Examiner must USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 XNever Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify. þ Specify: white 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) disabled none 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Otis Kicklighter Catherine Neugerbower ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christina Snyder/niece permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is any Injury or other trai once. 16508 Virginia Avenue Williamsport, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility Ronald S Director State Anatomy Board Baltimore, MD 21201 655 W. Baltimore Street 2 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) **Physician** Coneman /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed and -trans physician ar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical as use 23c. If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy -0 in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a detached for 9 Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown as been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 21 No page certificate 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) 2**___**No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 ☐ Yes 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural
2 Accident (Month, Day Year) 5 Pending investigation M 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

or Attending Physician: within 24 hours after death.

To the Funeral Director: / within 24 hours a

To the Funeral 6 To the Hospital

> State Registrar

Medical

29a. Certifie

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) MAR 0 5 2010



and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

Street Hagestern 190 21740

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 03:45 AM ORRAINE KNOSEN 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MEDICAL BALTIMORE UNIVERTITE GF CAMP CENTER 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign Social Security Number 6. Sex 8. Date of Birth **Funeral** (Month, Day, Year) 1 🗆 M 2 🔀 F Months Days Hours Min. Country) **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number Funeral USA <u>80616</u> 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces?
1 ☐ Yes 2 No Black, White, etc. 1 Never Married 2 Married Š Baltimore, Maryland 21215-0036 1 ☐ Yes 2 KNo Specify. If Yes Give inite 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Knos Spouse mond 20a. Method of Disposition 20b. Place of Disposition (Name of Date UVUK 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fund al Service License 22. Name and Address of Facility 123 10, Jessup 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final disease or condition Physician/ ADRTIC STENO SI Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 📉 No Month 5 Other (specify) Pregnant at time of death ned by the an e detached for 9 Unknown P.0. Part II. **Other significant condition**s contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed I þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed been si 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2: autopsy 2 No 1 Yes Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2 No 1 Yes ည 1/S Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After completed filled in by the funer (Month, Day, Year) work? 1 ☐ Yes 2 ☐ No injury 1. Natural 5 Pendina Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie

State Registrar UNIVERSITY OF 31. Date filed (Month, Day, Year) NAR 0 5 2010

MODICAL 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARY CAM

OF

1316172240

CONTER 22 5 GREENE ST

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		-	For State Registrar		State of IVI	aryiand		tificate of D		and w	-	Reg. No.	2010	0	16663
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	/ Examini	eı			land Hosp	ital		Clinton				Prince George'			's
	Funeral		5. Social Security Nu	mber 6. Se	ex 7. Age	e (In yrs. last		If Under 1 Year Months Days		r 24 Hrs. Min.	8. Date of Birt (Month, Da	th	9. Bir Co	thplace (S	State or Foreign
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Ball	permit. Pag Department Important: any injury o		21. Signature Fun	eral Service Licens		015		. Name and Addres						2073	
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Division of Vital Records, P.O.	that the	by Ph	Part II. Other signific	cant conditions c	ontributing to death b	ut not resul	ting in the u	nderlying cause giv	en in Par	rt I.	23e. Did t	obacco use	e contribute to	o the caus	se of death?
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_	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completed filled in by the funeral director, page 2 should be detached for use an example of the completed filled in by the funeral director, page 2 should be detached for use an example of the completed filled in by the funeral director, page 2 should be detached for use an example of the completed filled in by the funeral director.	Medical			sician: To the best of iner: On the basis of e										and manner stated.
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	~		30. Name and addre	ss of person who	completed cause of d	leath (Item 2	23a) (Type, F	rint)	٠,	11.	01-0	, vv	dn	171	2=
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🎧 = State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2010 Physician/ March 4, 7:30 AM Jacqueline C. Kramer Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Towson Gilchrist Hospice Center 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Days July 1, 1931 Months Hours California Director 572-38-7850 78 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 72 hours after death with the Maryland Director 1 ☐ Yes 2 🖾 No Ellicott City MD Howard 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number Funeral USA 21043 2510 Kensington Gardens #207 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Armed Forces?

1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ≥ 1 Never Married 2 Married Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify. If Yes Give 3 Widowed 4 X Divorced Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Banking Bank Teller Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Alice Louise Lesch Delmar R. Capell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 34 Old Granary Court; Catonsville, MD 21228 Son Donald Barrick Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) March 8,201 Glen Burnie, MD Atlantic Crematory 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Si natu e of Funeral Service Licen 21228 Avenue; 1630 Edmondson 23a. Part 1. Enter the disease, or complications that caused the death Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Exami Cause (Disease or iinjury that initiated events and Due to (or as a consequence of): resulting in death) Last physician a Physician/Medical P.O. Box 68760 the attending phone IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) or Attending Physician: The law requires that the death in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death
Unknown been signed by the sahould be detached 1 ☐ Yes 2 ¼ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy perform 1 ☐ Yes 2 ☐ No ☐ Yes this certificate ours after death.

eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 2 **N**No 1 Inpatient 2 ER/Outpatient 3 DOA 1 🗌 Yes ၉ 4 Nursing Home 5 Residence & Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: iniury work? 1 ☐ Yes 2 ☐ No 1 Matural 5 Pending 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital o within 24 hours af To the Funeral Di completed filled in Medical 1 😾 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as state only one 29b. Signature and title of certifie 29c. License number March 4 2010

Registrar
DHMH 17 Rev 7/2009

State

Name and address of p

31. Date filed (Month, Day, Year)

10

rson who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#5&8perFH, G901, 3/16/2010, WS
State of Maryland / Department of Health and Mental Hygiene 06665 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day March 2, 2010 Year Physician 6:30 P M Ruth Paula Kiskis /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner
 St. Agnes Hospital

 5. Social Security Wigher
 6. Sex

 212-30 4198
 ¹□ M
 Baltimore
If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Pay, Year) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 🖼 F Months Hours Maryland 78 Director 1931 Dec Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a State 10d. Inside City Limits 28a-f show Examiner must be notified at 1 ☐ Yes 2 👿 No Director MD Howard Jessup 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō Pages 1 and 2 should be filed within 72 hours after death with or items 23a 20794 Funeral 8354 Gatewood Drive USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. Black, White, etc. 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No White ≥ If Yes, Give Year or Dates Specify Specify: 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) of Health and Mental Hygiene. item 27 is marked other than other traumatic event, the M 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Braitsch Paula Bryan ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Kiskis Son 405 Little Marvel Ct. Pasadena, MD 21122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Holy Redeemer Cemetery 3/8/2010 20c. Location - City or Town, State permit. Pages 1
Department of F
Important: If ite
any injury or ot
once. 1 対 Burial 2 ☐ Cremation 3 ☐ Removal from State |Baltimore, Maryland 4. □Donation 5 □ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Sunature of Funeral Service Licens 1630 Edmondson Avenue; Catonsville MD 21228 23a. Part 1. Enter the disease, or complications that caused the death. To not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if a y, leading to infine diate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d, Date of delivery 3 Ectopic pregnancy Month Year Day 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 2 1 No 1 ☐ Yes 2 □ 110 1 ☐ Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Medical Certification: To Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation ours after death. neral Director: At filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral C

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar H

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

040

5 2010

31. Date filed (Month, Day, Year)

PREGERATE RO

OBMAAN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 2:50 March 4. 2010 Bertha Beiff Levine /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Silver Spring
If Under 1 Year | If Under 24 Hrs. Montgomery Riderwood Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Year) Days Hours 1 □ M 2 🖔 F Yrs Jan. 2, 1918 Massachusetts 92 Director 028-01-1663 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d, Inside City Limits show ral", or items 23a or 28a-f shore 1 ☐ Yes 2 ☑ No Funeral Director Maryland | Montgomery Silver Spring 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20904 3160 Gracefield Road United States Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?
1 □ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2X No Specify <u>ک</u> Specify White 3 \ Widowed 4 □ Divorced "natural", Completed the Medical 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Office Manager Law of Health and Mental Hygie fitem 27 is marked other t r other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Annie Shambad 2 Aaron Beiff 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other trau Pages 1 and 2 14523 Woodcrest Drive, Rockville, Maryland 20853 Paul Levine/Son Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 😿 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Montgomery Crematorium, Inc. March 5, 2010 | Bethesda, Maryland 21. Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Bethesda—Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814 M01548 Approximate Interval Between Onset and Death Part I. Enter the disease or complications that caused the shock, or heart failure. List only one cause on each line. r complications that caused the death pornot enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final disease or condition resulting in death) Reenover **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Examiner Due to (or as a consequence of) as the burial-transi and Due to (or as a consequence of): physician Physician/Medical IF FEMALE nse If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy detached for Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown law requires that the à signed 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Records, 2 X No 1 🗌 Yes 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy or Attending Physician: The certificate I Vital 1 ☐ Yes director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital: Other: 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To ō completely filled in by the luneral 27. Manner of Death

1 Natural

2 Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Division 5 ☐ Pending investigation М 1 ☐ Yes 2 ☐ No a er death. 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Hospital within 24 hours a

To the Funeral I 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one)

State Registrar

8/61/61

Oct 12/

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

Loveen J. Puthumana,

30. Name and address of per n who completed cause of death (Item 23a) (Type, Print)

M.D.

3. Registrar's Signature

29c. License number

3110 Gracefield Road, Silver Spring, Maryland 20904

D59524

29d. Date signed (Month, Day, Year)

March 4, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Rea. No Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Feb. Physician/ 201Ö 12:10P [™] Loukonen, Jr. David Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Baltimore Co. Timonium Stella Maris Hospice Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours Min. (Month, Day, Ye. Country) Maryland 1 X M 2 🗆 F 89 214-14-0157 Director April Usual Residence of Decedent show 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location death with the Maryland Director or 28a-f s notified 1 ☐ Yes 2 🖾 No Dunda1k Baltimore MD 10g. Citizen of What Country? 5 10e. Street and Number 10f. Zip Code pe Funeral 21222 United States 23a 35 Waterview Road Examiner must Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. ō Completed by 1 Never Married 2X Married 2 X No Yes Page 1 and 2 should be filed within 72 hours after 21215-0036 1 ☐ Yes 2X No Specify: "natural" 3 Divorced 4 Divorced White Year or Dates 27 is marked other than "natu traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Hygiene Steel Industry Steelworker 3 Years and Mental Hygie is marked other Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Bertha Linquist David Loukonen, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

21136 19a. Informant's Name/Relationship (Type, Print) 4723 Pleasant Grove Road item 27 Brenda Fenloch (Niece) injury or other Baltimore, Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Department of H Important: If ite ₩XBurial 2 ☐ Cremation 3 ☐ Removal from State Sacred Ht. of Jesus Cem. 3/3/2010 Dundalk, Maryland □ Donation 5 □ Other (Specify) Signal ve of Funeral Service Licensee ²²Duda-Ruck funeral Home of Dundalk, Dundalk, Maryland 21222 7922 Wise Ave. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line nterval Between Onset and Death Immediate Cause (Final disease or condition Physician/ DEMENTIA Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical the Hospital or Attending Physician; The law requires that the death certificate be Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy5 Other (specify) ____ in the past 12 months? for Month Day Year Pregnant at time of death g Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown 2 No Completed Were autopsy findings available prior to completion of cause of 24a. Was an Jas autopsy performed? Yes 2 N death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) of Vital Be 1 Yes Other: 2 X No 4 Nursing Home 5 Residence 6 L Other (Specify) HOSPICE 1 Inpatient 2 ER/Outpatient 3 DOA 2 28b. Time of 28c. Injury at work? 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28d. Describe how injury occurred Certificate: X Natural 5 Pending Division 2 No 1 Tes Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check XI Ceptifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one within To the 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) nd address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar **JACKIE**

CRNP

12:10 p.m.

2010

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TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

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niner	4a. Facility Name (If	_		4c. County of De							
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F	19a. Informant's Nar	me/Relationship	(Type. Print)		19b. Mailir	ng Address (Street			r, City or Town, State	, Zip Code)	
once. To Be Completed by Funeral Director			y / Cousin	l					umbia, MD		
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	1 □ Burial 2 □ 4 🖫 Donation		☐ Removal from State cify)	<i>=</i>		fts Registr	i	04/2010	Hanover,	Marvland	
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al Examiner	disease or condition resulting in death) Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): A Fib VC										
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b S	Part II. Other signific	cant conditions	contributing to death	but not resu	ulting in the u	nderlying cause giv	en in Part I.	23e. Did to		to the cause of death	
Completed								24a. Was a autops perfori	sy prior t med? death		
Be	25. Was case referre examiner?		Hospital:			Oth	26. Place of Dear				
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tion	1 Natural	5 ☐ Pending investigati	(Month, D	ay, Year)	Injury	Worl	yai ⟨? Yes 2 □No	Zou. Describe N	ow injury occurred		
Certification:	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	6 Could not determine	be 28e. Place of Ir	njury - At ho etc. <i>(Specify</i>	me, farm, str	eet, factory, office	3,410	treet and Number or n, State)	eet and Number or Rural Route Number, State)		
	(Check only 2	1 Certifying I	aminer: On the basis	of examinat	wledge, deat tion and/or in	h occurred at the til vestigation, in my c	me, date and place opinion, death occu	, and due to the c rred at the time, c	cause(s) and manner date and place, and d	as stated. lue to the cause(s)	
Medical C		itle of certifier	2			29c. Licens	e number 6928	30 2	3 2/10	nth, Day, Year)	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Year LAURENCE LAMOTT VIRGINIA P MMedical EBRUARY 2010 5 40 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK 5. Social Security Number **Funeral** If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth 1 □ M 2 🗹 F 095-38-9762 Months Days Hours Director Usual Residence of Decedent or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland traumatic event, the Medical Examiner must be notified at Completed by Funeral Director 10d. Inside City Limits FREDERICK FREDERICK MO 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5018 WHISPERING PINES LN. USA 21702 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give 3 Divorced Specify: WHITE Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) and 2 should be filed within Health and Mental Hygiene. em 27 is marked other tha Home MAKER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ KICHARA MATHISON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and Department of Healt, Important: If item 27 any injury or DR. JAMES LAMOTT Hus, 5018 WHISPERING PINES FREDERICK MD 21703 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) SMITHSBURG CREM, MAR, 3, 2010 SMITHSBURG Signature of Funeral Service Licensee 22. Name and Address of Facility 6ARY L. ROLLINS FUN HOME Rollin Jary L. 110 WEST SOUTH ST. FLOODRICK MO 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Encephalopathy Onset and Death Physician/ Hepatic disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate bause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
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1 Yes 2 No Month Pregnant at time of death 1 ☐ Yes ∠ ⊭ g ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No 2 🗌 No 1 🗀 Yes Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? ည 2 🗷 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 24 hours after death. Funeral Director: After this Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hou

To the Fune

completed fil 29b. Signature and title of certifier iomca MOD 67750 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

32. Registrar's Signature

744 5+

Bianca P Uduaampola-Stewart

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2010 Year **Physician** MARCH WILLIAM DAWSON LYNN 9:30A /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Lutherville Brightwood Genesis If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) NOV 9, 1918 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Marylánd 219-01-7164 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at XX Yes 2□No Directo Maryland Baltimore None 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21212 USA 323 Winston Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? XXYes 2 □ NoWWII If Yes. Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 and 2 should be filed within 72 hours after Health and Mental Hygiene. em 27 Is marked other than "natural", or ite 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes XX No Specify Specify: þ X3X Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) Medical Physician 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Clyde Dawson Frank Sidle Lynn 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any Injury or other trau
once. Son 323 Winston Avenue Baltimore, Maryland 21212 Thomas Key Lynn 20a. Method of Disposition
1 __Burial __202 Cremation 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 3 ☐Removal from State GreenMount Crematory Mar 4,2010 Baltimore, Maryland Donation 5 ☐ Other (Specify) 22. Name and Address of FMitchell-Wiedefeld Funeral Home Inc nature of Funeral Sen mes 6500 York Road Baltimore, Maryland 21212 ins the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ause on each line. 23a. Part1. Enter the disease or complicat shock, or heart failure. List only one Dementica Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner ous tate cunter Sequentially list conditions, if any, leading to immediate cause. Enter Underlying factors (justice figure) that initiated events resulting in death) Last Examine The law requires that the death certificate be execute Due to (or as a consequence of): Box 68760. attending physician Physician/Medical 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Dav 4☐Pregnant at time of death 5 ☐ Other (specify) Ö 9□Unknown 9 DUnknown Division or Vital Records, P. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 4 ☑Onknown 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performe 2 1 No certificate Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 2 ER/Outpatient 3 DOA P 1 Inpatient After this 27. Man or of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a
To the Funeral 6 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of cortified 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

31. Date filed (Month, Day, Year)

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TUWSON 32. Registrar's Signature

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State of Maryland / Department of Health and Mental Hygierie

1 - For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death 020 M **Physician** MARCH UI 2010 /Medical am 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City. Town, or Location of Death COURTLAND GARDENS PIKESVILLE BALTIMORE 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 7/13/1947 Funeral 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 1 M 2 F 62 213-52-1798 MD Director Usual Residence of Decedent Maryland 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Exercine must be nutified at 1 Yes 2 No Director MD BALTIMORE PIKESVILLE the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4 STONEHENGE CIRCLE, UNIT #1 or items 23a 21208 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 2 should be filed within 72 hours after and Mental Hygiene.

is marked other then "natural", or ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: þ Specify: WHITE 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) INVESTIGATOR-HOME IMPROVEMENT STATE OF MD 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) DAVID LEVY COHEN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: if item 27 is any injury or other tra GEORGE FRANK/FRIEND 8561 HORSESHOE ROAD, ELLICOTT CITY, MD 20b. Place of Disposition (Name of ANSIME Property EMITTAN PART TRACE) 20a. Method of Disposition 20c. Location - City or Town, State 1 🕅 Burial 2 □ Cremation 3 □ Removal from State CHĂIM CEMETERY ^¹ 4 □Donation 5 □Other (Specify) 3/4/2010 BALTIMORE, MD 21. Signature of Funeral Service Lice 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician aunt Myrcyc resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, I any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine burial-transit that initiated events resulting in death) Last Due to (o/as a consequence of): the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) Š Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably 4 Onknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has Division of Vital 1□ Yes 2□No Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one, examiner's Hospital: 1 ☐ Inpatient Other: Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 2 ☐ EB/Qutpatient 31 DOA his 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of After 28d. Describe how injury occurred Certification: Injury 1-Natural 5 Pending death. 1 Tes 2 No 2 Accident investigation Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) berson who completed cause of death (Item 23a) (Type, Print) 19 W 31. Date filed (Month, Day, Year) Registrar's Signature State 0 5 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ FEBRUARY 28 2010 06:20P M LOBE STEVEN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 7121 PARK HEIGHTS AVENUE, BALTIMORE N/A #209 Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) MD **Funeral** Days 057077 1950 **Director** 217-50-5246 59 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f ehrmining or other traumatic event, the Medical Emman 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No MD N/A BALTIMORE 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7121 PARK HEIGHTS AVENUE, #209 21215 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 X Never Married 2 Married Completed by 1 ☐ Yes 2 🕅 No Specify: 3 Widowed 4 Divorced Specify: WHITE Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) SALES **COMPUTERS** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) LOBE WILLIAM BEATRICE MILLER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6794 ENTRADA PLACE, BOCA RATON, FL 33433 RANDI BLOOM / NIECE 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State ARCTNGTON CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 03/04/2010 BALTIMORE, MD 22. Name and Address of Facility SOL LEVINSON & BROS., 8900 REISTERSTOWN ROAD, PIKESVILLE, 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death ₽hysician/ disease or condition resulting in death) Medical Examiner nrovi Sequentially list conditions, Examine any leading to immedicause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and Due to (or as a Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Pregnant at time of death Yes 2 No g Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a, Was an 24b autopsy 1 Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? Natural 5 Pending injury Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the pest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of cer

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day,

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eted cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ James Muir McEachern March 2010 3:47 P Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1**X** M 2 □ F April 25,1938 384-36-0072 Michigan Director 71 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director ms 23a or 28a-f s must be notified MDMontgomery Rockville 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 208 Forest Ave. 20850 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2XXNo If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 filed within 72 hours after 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 Divorced Specify: Completed White Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) ntal Hygiene. ced other than " event, the Mer Elementary/Seconday (0-12) College (1-4 or 5+) Communications Radio Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) nd Mental F marked o .. Page 1 and 2 should be file tment of Health and Mental tant: If item 27 is marked o ၉ Thomas McEachern Virginia Warthin Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary E. McEachern / Wife 208 Forest Ave., Rockville, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Chesapeake Crematory 1 Burial 2 XCremation 3 Removal from State 3/5/2010 Beltsville, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses Rapp Funeral and Cremation Services 933 Gist Ave., Silver Spring, MD MO1585 Relbac Hac 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Metastatic Lung Cancer years disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Cardiac Tamponade days Sequentially list conditions Examine cause. Enter Underlying burial-transi Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? 1 Yes 2 L 9 Unknown Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death? performed? 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Inpatient 2 🗆 1 ☐ Yes 2 X No Other: မှ ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 5 Pending 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined

Box 68760 P.O. Division of Vital Records, the Hospital

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 🙇 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D69129

9901 Medical Center Dr., Rockville, MD

March 3, 2010

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jason M. Prior M.D.,

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Jean Α. Murphy 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Raltimore Square SP 5. Social Security Number 40 0 Ta If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) Funerai 1□M 2₩F Months Days Hours Min. Director 216-30-6664 75 July 7,1934 Maryland Usual Residence of Decedent 10d. Inside City Limits 10a State 10h. County 10c. City. Town or Location 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director MD Baltimore Baltimore Co. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 21224 7016 Gough Street United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ∏Yes 2⊅No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Morphy Jean Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No à Specify. Specify: 3 Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 is and Mental Hygiene.
7 Is marked other than "n Elementary/Secondary (0-12) College (1-4or 5+) 12 Years Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Casimer Lipka Mary Wieczynski ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David C. Murphy (Son) 8508 Kavanagh Road Dundalk, Maryland 21222 Important: If item 27 any injury or other *** 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Pages nemt of h 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 5 ☐ Other (Specify) Hilltop Service Corp. 3/4/2010 4 □ Donation Towson, Maryland 21. Signature of Jun Ja Service Licens Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last nel Due to (or as a consequence of) Exami The law requires that the death certificate be executed and Due to (or as a consequence of) Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Year Day 5 Other (specify) signed by the a o 9 Unknown 9 Unknown σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I page 2 s autopsy certificate 1 🗆 Yes 1 🗌 Yes 2 🗆 No Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 5 ☐ Residence 6 ☐ Other (Specify) this : After thi 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred Division Hospital or Attending 5 Pending investigation death. 1 Yes reral Director: / 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide within 24 hours a

To the Funeral I 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated 29b. Signature apo title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D65094 ed cause of death (Item 23a) (Type, Print) 30. Name and address of person

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			State Registrar 1. Decedent's Name (First, Middle	/ act)		Cei	tificate of L	Death			Reg. N	0.2		165/5	
	Physicia Medic		ROHAM MA		BIE					2. Date of Dea	D	ay 02	20 to	3. Time of Death	
	Examin		4a. Facility Name (if not institution	, give street and nun	nber)		4b. City, Town, o	r Location o	of Death			c. County		1 1 1 1 1	
	Funeral		JOHNS HORKINS M 5. Social Security Number	EOKAL C		s. last birthday)	BALT I	/ M O A	24 Hrs. T	8. Date of Birt	h		g Birthr	place (State or Foreign	
	Director		308-16-2770	1 □ M 2 🂢 F	88	Yrs.	Months Days	Hours	Min.	May 31	y, Year) 19	21	Coun		
	nd thow at	'n	Usual Residence of Decedent 10a. State 10b. County		10c.	City, Town or Lo	cation						1	0d. Inside City Limits	
	Maryla 28a-f s atified	Director	MD Ba	ltimore				Bal1	timor	e Co.				1 ☐ Yes 2 🄀 No	
	th the	al Di	10e. Street and Number 7809 Eastdale	Road		<u> </u>	10f. Zip Code						What Cour		
	eath wi	Funeral	11, Marital Status	12. Was Dece	edent Ever in		Was Decedent of H	224 Iispanic Orig	gin? (Spec	cify Yes or No-	Un:	r	Stat e - Americ		
36	ifter de ", or it amine		1 Never Married 2 Mar	If You Giv		1	f Yes, specify Cuba	an, Mexican	, Puerto F	Rican, etc.)		Blac	ck, White, e	etc.	
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Maryland 21215-0036	2 should th and N 27 is ma trauma		19a. Informant's Name/Relationsl Rohemma Sprou		nter)		ng Address (Street								
σū	of Health of Health of Item 27	-0	20a. Method of Disposition		20b	D. Place of Dispo	sition (Name of natory or other place	re)	D	ate	20c. l	Location -	· City or To	wn, State	
E E	. Page tment tant: If jury or		1 Burial 2 XCremation 4 Donation 5 Other (S	Specify)	State	Hilltop	Service	Corp.	3/5/	/2010	Т	owsor	n, Ma	ryland	
Bal	permit. Page 1 a Department of h Important: If ite any injury or ot	Į,	21. Signature of Fineral Jersey L	icensee/	-	I	Name and Addre Ouda-Ruck 7922 Wise	Fune	ral H	Home of	Du	ndall	k, In	c. 1222	
I			23a. Part 1. Enter the disease, or shock, or heart failure. List of	complications that only one cause on ea	caused the de							, , , , ,		Approximate Interval Between	
	h sician/ Medical	i n	Immediate Cause (Final disease or condition resulting in death)	a. I	SCHE	1910	1202	TIS					- 1	Onset and Death 2 days	
	Examiner						ON M							8 hours	
	p ä	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying											1 day	
	xecute າ and al-trans	Exar	Cause (Disease or iinjury that initiated events resulting in death) Last	c. Due to	(or as a conse	9 0 K [/	1 ·							1 ong	
09	ate be executed physician and the burial-transit	dical		d											
687	eath certifica attending ph for use as tl	/Me	IF FEMALE:	23c. If yes, out	tcome of pred	inancy				-		00.1.0			
Вох	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transi	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1 Live	Birth 2 F	etal death 3 🛚	Ectopic pregnand Other (specify)	Э			Ì	Mo	te of delive onth	Day Year	
, P.O	requires that the de been signed by the should be detached	by	Part II. Other significant condition	ns contributing to d	leath but not i	resulting in the u	nderlying cause give	ven in Part I						e cause of death?	
ords	requir been s	Completed								24a. Was a		24b. \	Were autor	osy findings available	
3ec	The law ate has page 2:	Somp								autop perfo	rmed?	No.	orior to cor death? 1 🔲 Yes	npletion of cause of	
ta	ysician: The is certificate director, pag	Be	25. Was case referred to medical examiner?	Hospital:				ace of Deat	h (Check						
<u>></u>	is d	e: To	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date	of injury	ER/Outpatier 28b. Time of	ot 3 DOA Other	4 L. Nu		ne 5 🗌 Resid 8d. Describe h					
ono	uttending death. ctor: Afte y the fun	ficat	1 Matural 5 ☐ Pendir 2 ☐ Accident Investig	gation	th, Day, Year)	injury	M 1 🗆	? Yes 2 🗆			,				
Division of Vital Records,	l or Atten after deat Director: I in by the	Certificate:	3 Suicide 6 Could 4 Homicide determ	ined 28e. Place	e of Injury - At ing, etc. (Spec		eet, factory, office		2	8f. Location (S City or Tow			er or Rural	Route Number,	
	To the Hospital or Attending Pt within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral	edical	(Check 2 Medical E		sis of examina	tion and/or invest	igation, in my opinio	on, death oc	curred at t	he time, date a	nd plac	e, and due	e to the cau	ise(s) and manner stated.	
	To the within 2 To the comple	M	only one) 3 Certifying 29b. Signature and title of certifier	Nurse Practioner:	To the best of	my knowledge, o	death occurred at the 29c. License		and place				anner as sta d (Month, D		
			Day LIN	IDA MO	BUCA	/HD	. RE	5.00	01		M	arch	2/4	2010	
			30. Name and address of person to LINOA HOBULA	4940 F.	ASTER	NE AVE	BALTI	HOLE	, H	0 2/2	224	1			
	Stat Registra		31. Date filed (Month, Day, Year)	32. R	legistrar's Sig	ature And	e)		··						
	negistra	at .	MAK O D ZI	IIU WENT	- P	7									

DHMH 17 Rev 7/2009

10-01761
Michael Munk

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Michael Munk		1- For State Registrar		ate of Maryla		ertificate o		d Mentai		Reg. No.	201	0 0667	
Physic Medical Exam		1. Decedent's Nam Michael	ie (First, Middle	e,Last)		Mur	k		2. Date of De Month March 1 ,	Day	Year	3. Time of Death 1119 hrs	
		4a. Facility Name (Franklin Sq		n, give street and nu tal	imber)		4b. City, Town, or Rosedale	Location of De		4c.	County of Dea		
Funeral Director		5. Social Security 1 212-58-43		6. Sex	7. Age (In yrs	s. last birthday) Yr:	If Under 1 Year Months Days		Hrs. 8. Date of B	,	Fore	Birthplace (State or eign country)	
ny		Usual Residence o			10c. Ci	ity, Town or Loca	tion			10d. Inside City Limits			
te Maryland or 28a-f show any fied at once.	<u></u>	MD	Baltim	ore		kville			1 Yes 2				
Maryla - 28a-f.	Director	10e. Street and Nu	mber				10f. Zip Code		I	10g. Citize	en of What Co	untry?	
vith the s 23a or	al Di	3006 Texa:	s Avenue	12. Was Dec	edent Ever in	U.S. I 13 Wa	21234 13. Was Decedent of Hispanic Origin? (Spe				J.S.A.	erican Indian, Black,	
death v or items	Funeral	1 X Never Marri	ed 2 Ma	Armed Fo		lf Y	es, specify Cuban				White, etc.	, July	
rs after ural", o	by F	3 Widowed		orced If Yes, Give Yea or Dates: ify only highest grad	Г	1	Yes 2X No		of work done		Specify: Wh	ite	
5 72 hou: n "nati	leted	Elementary/Second		College (1			Decedent's Usual Decupation (Give kind of working life, DO NOT use retire			TOD. KI	nd of business	s in dustry	
OO36 within giene. her tha	Completed	12 17. Father's Name	/Eiret Middle	l aet)		Fire Fi	0	18 Mother's Na	me (First, Middle,		y of Bal	timore	
215- be filed ntal Hyg rked of	Be C	Melvin	(First, Middle,	Last)	M	unk		Doris	me (First, Middle,	, ivialdell a	ourname)	Ciscle	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked the than "naturalt", or items 23a or 28a-f shou injury or other traumatic event, the Medical Examiner must be motified at once.	To	19a. Informant's Na Doris M	ame/Relationsh unk, Moth		_		g Address (Stree dgar Terra				y or Town, Sta	te, Zip Code)	
re, M 1 and 2 Health Fitem 2		20a. Method of Dis	position				sition (Name of cen		Date	_	ocation - City o	or Town, State	
Baltimore, permit. Pages I at Department of Hee Important: If ite		4 Donation 5	Other Sp	ecify:		ardens of	Faith		3/05/2010		timore,	MD	
Balt permit Depart Impor		21. Signature of Fu		Licensee R Pslai			Name and Address 05 Harford						
Physician		23a. Part I. Enter th		complications that ca	aused the dea							Approximate Interval Between Onset and	
/Medical Examiner		Immediate Cause (or condition resulti	Final disease	a. Mixed	drus (I	morphine	, methad	one, di	phenhydi	ramin	e)	Death	
	Ĺ	Sequentially list co		b									
	Examiner	if any, leading to in cause. Enter Unde (Disease or injury t	erlying Cause	Duc to (or as a									
uted nd ransit	Exa	events resulting in		Due to (or as a d.	consequence	e of):							
50, te be executed ysician and burial - transit	edical I	XUNPENDED		AMENDED	23a , 27	,28a-f,p	ermE, g9	01 3/9/	10 TT				
1876(Tificate ing phys		IF FEMALE: 23b. Was decedent past 12 months		23C. If yes, C	outcome of pre	egnancy	tal death 3	Ectopic preg			Date of delive	ry Day Year	
Sox 6876(leath certificate e attending phy-	/sician/N	1 Yes 2		- I ' -	ant at time of	death 5 O	her (Specify)						
the ched	by Phy	Part II. Other signi	ficant condition	ons contributing to		t resulting in the t	ınderlying cause g	iven in Part I.				the cause of death?	
cords, P.O law requires that has been signed to 2 should be deta.									- 1 Ye			obably 4 Unknown utopsy findings available	
e law re e has be	Completed								auto perfe	psy ormed?	prior to death?	completion of cause of	
Vital Reco ysician: The law his certificate has director, page 2 s	രി	25. Was case refer	red to medical					of Death (Che	, ,	2 No	1 V Y	es 2 No	
f Vit. Physici er this c	To B	examiner? 1 Yes 27. Manner of Deat	2 No	Hospital: 1 li		ER/Outpatient		Other 4 Nur	sing Home 5	Residence		er:	
on of \ on of \ ending Ph; ath. or: After the funeral	tion:	1 Natural	5 Pendi	Month, ng Fd 3/	Day,Year)	Fd 10:3		es 2 No	unk	rnow injury	y occurred		
ivision or Attendath after death Director:	Certification:	2 Accident 3 Suicide	- 	not be 28e. Place	e of Injury - At	home, farm, stre	et, factory, office bu					ural Route Number, City	
Division To the Hospital or Attent within 24 hours after death fo the Funeral Director: completely filled in by the		4 Homicide		ysician: To the besi			mily res					rkville, MD	
To the Ho within 24 Fo the Fu	Medical	2 🔻	Medical Exan	niner: On the basis of and manner st	of examination		tion, in my opinion,	death occurre					
	Ž	29b. Signature and	title of certifier	10000	. ^		29c, License O.C.N				ate signed <i>(Mo</i> h 2, 2010	onth, Day, Year)	
	П	30. Name and addr	ess of person	who completed caus	e of death (Ite	em 23a)							
		Carol Allan,		istant Medical I			Street, Baltimo	ore, MD 212	201				
S Regis	tate	31. Date filed (Mont		2010 32.1	gistrar's Signa	ature &	11						

DHMH 17 Rev 1/2001 OCME 2006

OCME

ORIGINAL

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- State Amend #17, per FH G902 4/15/10 TT. Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 10:10 PM LLER Donna Lynn Miller MARCH 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HARBOR HOSPITAL BALTIMORE 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth (Month, Day, Year) 11/07/1943 7. Age (In yrs. last birthday) Funeral Hours Months Days 1 □ M 2 🛣 F Director Maryland 218-46-1196 66 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show event, the Medical Examinar must be notified at 1 X Yes 2 ☐ No Directo MD Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 2709 Wegworth Lane 21230 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or If Yes, Give Year or Dates: 1 □Yes 2 🔀 No Specify: þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) of Health and Mental Hygiene. If Item 27 is marked other thar Clerical Medical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Miller Jesse Eugene Miller Virginia Laura မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Munderloh / Cousin 9895 Palace Hill Drive, Apt. 109, Laurel, MD 20723 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page:
Department o
Important: If
any injury or
once. **=** 5 4 ☑ Donation 5 ☐ Other (Specify) Anatomy Gifts Registry 03/04/2010 Hanover, Maryland 22. Name and Address of Facility Anatomy Gifts Registry 21. Signature of Funeral Service Licensee 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) ECOMPENSATED CONGESTIVE /Medical Due to (or as a consequence of): Examiner SEPSIS SEVEN DAYS Sequentially list conditions ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) To the Hospital or Attending Physician: The lav requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has seen signed by the attending physician and completely filled in by the funeral director, age 2 thould be detached for use as the burnal-transit Exami SACRAL DECUBITUS ULCER STAGE FOUR Due to (or as a consequence of) P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Year Day 5 ☐ Other (specify) ☐Yes 2 ☐No 9 Unknown 9 Kl Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24a. Was an Were autopsy findings available prior to completion of cause of autopsy death? 1 ☐ Yes 2 🗷 No 1 □ Yes 2 🔀 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 🗵 No 1 Natient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 □Yes 2 □No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD DADUSUMILLI RES 000 MARCH 2 2010

State Registrar

DHMH 17 Rev 1/2001

BALTIMORE.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SESHA ADUSUMFLL TO SESHA ADUSUMFLI TO SESH

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ avia 03 0:44 PM Medical not institution, give street and number) Examiner City, Town, or Location of Death 4c. County of Death Baltimore Kaven -och Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** If Under 24 Hrs. 8. Date of Birth 1 **K**M 2 □ F Min. Director or 28a-f shov 10a. State 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director Yes 2 No 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. "natural", Completed 3 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DQ NQT use retired) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me College (1-4 or 5+) Sethleha Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle ည avi's 19b. Mailing Address (Street and Number 20b. Place of Disposition (Na cemetery, crematory or c 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Funeral Service Licer see ries Mo 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death UKENOWA shock, or heart failure. List only one cause on each line Immediate Cause (Final) Physician/ -arcinoma disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): cal Box 68760 use as the Physician/Medi 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) Month Dav Year Pregnant at time of death signed by the a 1 ☐ Yes 2 L 9 ☐ Unknown Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b lirector, page 2 s autopsy performe 2 🗆 No Division of Vital funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No ျှ ✓ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer. 1 Natural 5 Pending work Accident 1 Yes 2 🗌 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 [Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) address of person who completed cause of death (Item 23a) (Type John S. Lah, m.D. Raven Baltimore, Maryland 21218 3900 Loch owlevard. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Physician /Medical 4c. County of Death Examiner 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days **Director** Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show amy injury or other traumatic event, It.a. Medical Examilitar must be notified at once. 1 des 2 □ No Director 10g, Citizen of What Country? 10e. Street and Number by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, 11. Marital Status Black White etc 1 ∐Yes No If Yes, Giv Year or Dates: 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 📶No 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ndary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Trvic Licensee Mo Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dynshock, or heart failure. List only one cause on each line. Immediate Cause (Final YEARS **Physician** CARDIOVASCULAR ATHOROSCUOROTTC disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) burial-transit Physician: The law requires that the death certificate be execut and Due to (or as a consequence of): Box 68760, physician the burial Physician/Medical attending phase as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 5 Other (specify) P.O. the 9 Unknown cate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Hinknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 2 1 No 2 🗆 No Division of Vital 1 □ Yes 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To After this funeral d 28a. Date of injury (Month, Day, Year) To the Hospital or Attending Pt within 24 hours after death.
To the Funeral Director: After it completely filled in by the funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending 1 ☐Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🗜 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D31136 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month.

ACCACE WWD
32. Registrar's Signature

9005 KILBRIDE RD, BALTIMORF, MD 21236

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2000 /Medical 4a. Facility Name (If not institution, give street and number Jown, or Location of Death 4c. O anty of Death Examiner Sal a 8. Date of Birth (Month, Day, Year) 9. Birthplace Country) Social Security Number 6. Sex **Funeral** 1 □ M 2 F Days Months 2-30 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. ant: If item 27 is marked other than "natural", or Items 23a or 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Oppartment of Health and Mental Hygiens. Inhortant: if item 21 as marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, it is recipied. 1 Yes 2 No Completed by Funeral Director 10e. Street and Number 10g. Citizen of What Country? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Be Lewis (Type. Print) daughter 19b. Mailing Address (Street and Number or Ru Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other) 1 X Burial 2 ☐ Cremation 3 Removal from State 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 23a. Part1. Enter of disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Boune **Physician** SMALL /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if or y, leading to inimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Que to for as a consequence off Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760 Physician/Medical yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 🏋 Unknown Be Completed 24a. Was an autopsy performed' 1 ☐ Yes 2 24b. Were autopsy findings available prior to completion of cause of death? 2 □No □Yes 1 TYes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 \(\sum \) Nursing Home 1 ∐ Yes 2 🗫 o Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 🗌 Residence 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 Accident 5 Pending 1 □Yes 2 □No investigation 24 hours after death Funeral Director: 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 🗫 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mapner stated. (Check only one) within 24 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar 31. Date fil

address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

			State of Maryland / D			tal Hygie	ne 2010	06681
			Registrar	Certificate of Death			No UIU	00001
	Physicia	ın/	1. Decedent's Name (First, Middle, Last)		M	ate of Death Ionth	Day Year	3. Time of Death
	Medic	cal	ELEANOR HAMBY MARTIN 4a. Facility Name (if not institution, give street and number)			RCH 3,	2010	6:18 A M
	Examin	ier		4b. City, Town, or Location	of Death		4c. County of Death	
	Funeral		UPPER CHESAPEAKE MEDICAL CENTER 5. Social Security Number 6. Sex 7. Age (In yrs. last birth		er 24 Hrs. 8. Da	ate of Birth	HARFORD 9. Birth	place (State or Foreign
	Director		216-12-9975 1□ M 2 😿 89 Y	rs. Months Days Hours	Min. (M	Nonth, Day, Yea	ar) Cour 1920 Ma	ryland
	t ow		Usual Residence of Decedent 10a, State 10b, County 10c, City, Town	- Leastion				10d. Inside City Limits
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:	or 28a notif	Dire	Maryland Harford Bel Air 10e. Street and Number	10f. Zip Code		100	. Citizen of What Cou	
7	with th	Funeral Director	2200 Creswell Road	21015		"	USA	y.
-	eath v	Ë	11. Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Or		es or No-	14. Race - Americ	ean Indian,
ထ္ဆ	ter de , or il	ğ	1 ☐ Never Married 2 ☑ Married Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give	If Yes, specify Cuban, Mexical 1 Yes 2 No Specify		, etc.)	Black, White,	etc.
	be filed within 72 hours after death with the Maryland antal Hygiene. A shall Hygiene than "natural", or items 23a or 28a-f sho ked other than "natural", or items 23a or 28a-f sho ic event, the Medical Examiner must be notified at	Completed	3 🗆 Widowed 4 🗀 Divorced Year or Dates.		y. 		Specify: W	nite
Maryland 21215-0036	72 ho n "na Jedic	e e	(Specify only highest grade completed)	Decedent's Usual Occupation Give kind of work done during mos ife. DO NOT use retired)	st of working	161	b. Kind of Business In	dustry
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0	Hyg othe /ent,	a	17. Father's Name (First, Middle, Last)		her's Name <i>(First</i>	t, Middle, Maid		
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<u>a</u>	shoulk and N is ma auma		19a. Informant's Name/Relationship (Type, Print) 19b.	Mailing Address (Street and Numb	ber or Rural Rout	te Number, City	y or Town, State, Zip	Code)
	and 2 s Health tem 27 other tra			00 Creswell Road	d, Bel A	Air, MC	21015	
= .			20a. Method of Disposition 20b. Place of I Burial 2 Cremation 3 Removal from State	Disposition (Name of crematory or other place)	Date	200	c. Location - City or To	own, State
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Ba	permit. Page Department of Important: If any injury or once.		21. Sign yurd of Funeral Service Licensee	22. Name and Address of Facili MCCOMAS Fune:				3 01000
			23a, Part 1. Enter the disease, or complications that caused the death. Do no	1317 Cokesbur			don, Mary	Approximate
			shock, or heart failure. List only one cause on each lines					Interval Between Onset and Death
4	nysician/ Medical		disease or condition resulting in death) A Cull SX Due to (or as a consequence of	Secondary (7 50	2.4. 15	- Mrs	
-	Examiner			Sewaday	& Pane	Jan	. 00	
-		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying					
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•	cian a	alE	resulting in death) Last Due to (or as a consequence of					
09/	physi the t	edical	d					
89	nding se as	N.	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy				23d. Date of deliv	erv
Box	atter d for u	Physician/Me	in the past 12 months? 1 Ves 2 No. 1 Pregnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			Month	Day Year
). E	oy the a	hys	9 Unknown 9 Unknown					
O. 4	gned be det	b F	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part	t I. 2		co use contribute to t	
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00	aw re las be	Completed by			2	24a. Was an autopsy	prior to co	psy findings available impletion of cause of
Re E	cate h				1	performed 1 Yes 2	death?	2 🗆 No
<u>ta</u>	certifi	Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital:	Other:	eath (Check only			
> 2	r this ral dii	<u>م</u>	1 Yes 2 A No 1 Inpatient 2 ER/Out 27. Manner of Death 28a. Date of injury 28b. Til	patient 3 LI DOA 4 LIN		Residence Describe how in	e 6 Other (Specifi	()
U .	th. • Afe	cate		ury work? M 1 \(\subseteq \text{Yes} 2 \subseteq \)	_	703011001104411	njary occurred	
Division of Vital Records,	r deg ector by the	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farr building, etc. (Specify)	n, street, factory, office			t and Number or Rura	Route Number,
	irs aft irs aft ial Dir led in		building, etc. (Specify)			City or Town, St		
	to the propriat or Attenuing Frigstrant: The law requires that the beam certificate be executed within 24 hours after death. Teath this certificate has been signed by the attending physician and completed filled in by the fureral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, do (Check 2 Medical Examiner: On the basis of examination and/or	investigation, in my opinion, death o	occurred at the tir	me, date and pl	lace, and due to the ca	use(s) and manner stated.
4	ithin 2 the 3	Ĕ	only one) 3 Certifying Nurse Practioner: To the best of my knowle 29b. Signature and title of certifier	dge, death occurred at the time, date 29c. License number			use(s) and manner as s Date signed (Month,	
	- ≥ - ⊠) (gishint mo	30067452			3/03/2010	
	G		30. Name and address of person who completed cause of death (Item 23a) (Ty	1				
	8		Wijstell moksie soo upper cles spe	pe, Print) whe a sul Air	ms 20	2.04		
	Stat		31. Date filed (Month, Day, Year) 22. Registrar's Signature	-00				
	Registra	ar	MAR 0 5 2010 Person for 1					

DHMH 17 Rev 7/2009

mothy Mason		State of Maryland / Department of Health and Mental H - For State Certificate of Death tegistrar		2010) 05682
Physiciar	1/	1. Decedent's Name (First, Middle, Last)	2. Date of Death Month February 2:	Day Year	3. Time of Death 1128 hrs
ical Examin		4a. Eacility Name (if not institution, give street and number) 4b. City, Town, or Location of Death		3, 2010 4c. County of Dear	
		4a. Facility Name (if not jr/stitution, give street and number) 4b. City, Town, or Location of Deatr 1400 North Dukeland Street Baltimore			
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs	s. 8. Date of Birth	(MM/DD/YYYY) 9. B	irthplace (State or
Director	ı,	579-(22-2542) 1 Mm 2 F 35 Yrs. Months Days Hours Mir	Jan 12	1975 C	ountry)
		Usual Residence of Decedent		///	10d. Inside City Limits
w any		10a. State 10b. County 10c. City, Town or Location			1 Yes 2 No
Maryland 28a-f show	힑	MD Baltimore	I10	. Citizen of What Co	
th the Maryland 23a or 28a-f sho notified at once	Director	10e. Street and Number	10,	y. 01112011 01 1111at 001	,
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il", or	교	3 Widowed 4 Divorced If Yes, Give Year or Dates:		Specify:	3 lack
nours a		15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Decupation (Give kind of during most of working life. DO NOT use ref		16b. Kind of Business	s/Industry
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215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica	Be C	Housed B. Mason Pame	la Li	wexu	
21 buld her man		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or	Rural Route Numb	oer, City or Town Sta	
MD d 2 sh lth and n 27 is aumat		Pamela Vason mother 1575. Augusta F 20a. Method of Disposition (Name of Commeter).	tve 13	20c. Location - City of	D 3 1330
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imore Pages 1 ment of H tant: If it	1		-6-10	Bockyill	e,MD
Baltimore, permit. Pages I al Department of He Important: If ite injury or other tr	1	21. Signature of Fu eral Service Li -nsee.	EH an	O Frishi	21339
Physician	+	23a. Lant J. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac	or respiratory arre	st, shock, or heart	Approximate Interval
/Medical	-	failure. List only one cause on each line.			Between Onset and Death
Examiner	١	Immédiate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):			
		Sequentially list conditions, if any leading to immediate Due to (or as a consequence of):			
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Box 68760 e death certificate be the attending physical ad for use as the bu	Z	23b. Was decedent pregnant in the next 12 months?	ancy	Month	Day Year
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ords, v requir s been s	etec		24a. Was a autops		autopsy findings available completion of cause of
Division of Vital Records, tal or Attending Physician: The law requirers after death. The law requirement of the tal or After this certificate has been simple to by the funeral director, page 2 should be in by the funeral director, page 2 should be a second to	Completed		perform 1 ✓ Yes 2	med? death?	
tal Reco	္စ္ပါ	25. Was case referred to medical 26. Place of Death (Check	(only one)		
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n of Vij ding Physi After this funeral dir		27. Manner of Death 1 Natural 5 Deadies FOUND: 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? FOUND: 1 Yes 2 ✔ No		ow injury occurred bed and cut	
ivision or Attendiater death. Director:	atio	2 Accident Investigation Feb 23, 2010 1120 hrs	20f Location /S	treet and Number of	Rural Route Number, City
in or A	Certification:	3 Suicide 6 Could not be determined (Specify) Single Family	or Town, St		
Divis Hospital or A 24 hours after Funeral Dire		29a. Certifier			
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate b within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the bu	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	at the time, date a	and place, and due to	the cause(s)
5 1 × 1 × 1	Š	29b. Signature and title of certifier 29c. License number		29d. Date signed (A	
		Mh Brand MD O.C.M.E.		February 24, 2	010
り		30. Name and address of person who ompleted cause of death (Item 23a)	201201		
0,		Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MI	J Z I Z U I		
Sta Regist	ate rar	31. Date filed (Month, Day, Y2010 A 32. Registrar's Sanatur			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 3 Physician/ Day 2 D 10 Mandell Sidney 5:50 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 10840 STEVENSON ROAD BALTIMORE <u>STEVENSON</u> Social Security Number 7. Age (In yrs. last birthday) Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Hours 1 □**X**M 2 □ F 93 **Director** 217-18-0937 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director MD N/A BALTIMORE 1 X Yes 2 No 10e. Street and Number 10f, Zip Code 10g, Citizen of What Country? Funeral 7121 PARK HEIGHTS AVENUE, #208 21215 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Tyes 2 No Specify: WHITE "natural", Specify: 3 ¥ Widowed 4 □ Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Meagness. Elementary/Seconday (0-12) College (1-4 or 5+) RESTAURANT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည NATHAN MANDELL GEITEL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10840 STEVENSON ROAD, STEVENSON. STEVEN MANDELL/SON MD 21153 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State CHIZUR AMUND CEMETER 03/04/2010 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) BALTIMORE. 22. Name and Address of Facility SOL LEVINSON & BROS., e of Funeral Service Lice se 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 Part 1. Enter the disease, or complication shock, or heart failure. List only one call that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Ph_{sician} 0 disease or condition Medical resulting in death) Due to (or as a co sequence of) **Examiner** months Sequentially list conditions, Examiner il any, leading to immediate cause. Enter Underlying Due to (or se a consequence of) Cause (Disease or iinjury that initiated events the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery Box (3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Yes 2 No 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2 1 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medica B B 26. Place of Death (Check only one) examiner? 2 No Other: 4 \sum Nursing Home 5 \sum Residence 6 \sup Other (Specify) 잍 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred Natural 5 Pending 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical

within 24 hours after death.

To the Funeral Director: After this certifica et completed filled in by the funeral director, pegr

MANDEL

SIDNE

EPS INCI/NIH Mark Schiffman MD 31. Date filed (Month, Day, Year)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

029776

1 🗸 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year) 3 3

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bethesda MD

State Registrar 29a Certifier

only one) 29b. Signature and title of certifie

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March Physician/ 201[°]0 Tack John 4:15 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Manor Care Chevy Chase Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🕅 M 2 🗆 F Months Hours January 18. ^{ar)} 1925 227-22-2322 85 Vîrginia Director Usual Residence of Decedent "natural", or items 23a or 28a-f show dical Examiner must be notified at within 72 hours after death with the Maryland 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 X Yes 2 No. Marvland Montgomery Chevy Chase 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5500 Friendship Blvd., Apt. 2028N 20815 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Was Decedent Ever In U.S.

Armed Forces?

1 X Yes 2 □ No 1943
If Yes, Give
Year or Dates. 1945 Black White etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White 3 Widowed 4 X Divorced Completed er than "natur the Medical E 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Salesman Automobile other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be filed th and Mental H 27 is marked of traumatic ever Frederick Nail E. Elizabeth Perry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 shi Department of Health an Important: If item 27 is any injury or other trau once. Josephine Pittiglio / Friend 5500 Friendship Blvd., Apt. 2028N, Chevy Chase, MD 20815 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 🗆 Burial 2 🛛 Cremation 3 🗆 Removal from State cemetery, crematory or other place) Montgomery Crematorium, Inc. March 4, 2010 Bethesda, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, 7557 Wisconsin Avenue, Bethesda, Maryland 208814-3501 Ingalate Suraut M01305 Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final NEUMONIA Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) sician and burial-transit Cause (Disease or imjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 as the l IF FEMALE: yes, outcome of pregnancy nse 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live Birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? ò Month Day Year 2 No the detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a, Was an the Hospital or Attending Physician: The law autopsy performe death? certificate 2-11VO 1 Yes funeral director, 25. Was case referred to medical Be 26, Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA After this Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 Yes 2 No Accident Investigation 24 hours after deat Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. filled in by 4 | Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. соmpleted 2 <u>|</u>3 <u>|</u> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) Ses, MA 312110 00057124 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Registrar

NAR 0 5 2010

DHMH 17 Rev 7/2009

Troung Bao, M.D.

31. Date filed (Month, Day, Year)

0. 10110 Molecular Drive, Rockville, Maryland 20850

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month RCH Year **Physician** 2010 12.51A /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location, of Death 4c. County of Death **Examiner** tonsville Baltmore Orest taver Vursino 8. Date of Birth (Month, Day, Tune 9, 1 Year | If Under 24 Hrs 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, If Undé Birthplace (State or Foreign Country) **Funeral** Days Min. Months Hours 1**∑**M 2□F 65 578-60-4530 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Baltimore Catonsville MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21228 USA Forest Haven Nursing Home Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1X Never Married 2 ☐ Married 1 ☐ Yes 2 🔀 No Specify: black 3 ☐ Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) unk 16a. Decedent's Usual Occupation unk 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any Injury or other traumatic event, the Me once. Elementary/Secondary (0-12) College (1-4or 5+) unk unk 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) Be 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21228 Forest Haven Nursing Home 701 Edmondson Avenue Catonsville, MD Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 21. Signature of Funeral Service Licensee Ronald S State Anatomy Board 655 W. Baltimore Street Director m Raltimore, MD 21201 Approximate Interval Between Onset and Death 23a. P. rt1. Enter the divides, if complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immedi te Cause (Final disease or condition resulting in death) HHEROSCH EREBROVASCUL DISEMS Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner and burial-trai Due to (or as a consequence of) attending physician Physician/Medical as the IF FEMALE: for use If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) the detached cate has been signed by , page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by NCEPH 1 Tyes 2 No 3 Probably A Donknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No 24a. Was an certificate has autopsy perform 1∐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No ۴ 1 Inpatient 2 ER/Outpatient 3□ DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

Physician /Medical Examiner law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

funeral director, After this Director: filled in by

or Attending Physician;

28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 🗀 No 2 Accident 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

(Check only one)

Certification:

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier MODIL

29c. License number

29d. Date signed (Month, Day, Year,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 283 TSNEEm

State Registrar

within 24 hours at To the Funeral D

completely

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Villatti i Ottei		I- For State Certificate of Death Registrar	nentai nyyi		20	0	06586
Physician	1/	1. Decedent's Name (First, Middle,Last) William R. Porter III	1.0	Date of Death Month	Dav Year		3. Time of Death
Medical Examine		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Locat		March 1, 20	4c. County of	Death	
		University of Maryland Medical Center Baltimore					
Funeral Director			Hours Min.		8,1960	Foreign	
any	-	10a. State 10b. County 10c. City, Town or Location					10d. Inside City Limits
and f show	<u> </u>	Md. Balto. White Marsh					1 Yes 2 No
more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland tent of Heath and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show any other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Elineral Director		10e. Street and Number 10f. Zip Code 5315 Bush Street 21162			g. Citizen of Wha	USA	A
or items;	runeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced If Yes, Sive Year 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, 2 No 1 Yes, Sive Year 1 Yes, Sive Year	xican, Puerto Rica		White,		an Indian, Black,
urs after tural" amine		15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (C	Give kind of work	done	16b. Kind of Busi		
5-0036 ed within 72 hour lygiene. other than "natu the Medical Exan		Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO f	NOT use retired)				
-003 withing giene.		12 Contractor 17. Father's Name (First, Middle, Last) Contractor	fother's Name (Fin		Self-Emp	p1oy	red
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the <u>Medica</u>			Kathleen				
D 21 should and Mea is man	2 '	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and	d Number or Rural	I Route Numb	er, City or Town,		
and 2 shorten 27 is traumatic	1/2	Karla L.Porter Spouse 5315 Bush Stre			20c. Location - C		
Baltimore, oemit. Pages 1 ar Department of Hea Important: If ite, njury or other tr	- 1	1 Burial 2 X Cremation 3 Removal from State crematory or other place)		010	D = 1 + =	Ma	
Baltin permit. P. Departmes Importan injury or	-	4 Donation 5 Other Specify: Bayview 21. Signature of Funeral Service Licensee - 22. Name and Address of Fa	3-8-2		<u>Balto.</u> uneral l		
12.	4	21. Signature of Funeral Service Licensee 22. Name and Address of Fa 9705 Be 1a 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such					21236 Approximate Interval
Physician /Medical Examiner		failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	ras cardiac or res	spiratory arres	st, shock, of fleah		Between Onset and Death
		Sequentially list conditions, b					
a di di		if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated					
ecuted and transit	E LY	events resulting in death) Last Due to (or as a consequence of): d.					
'60, ate be execut physician and he burial - tra		UNPENDED AMENDED					
ivision of Vital Records, P.O. Box 68760, or Attending Physician: The law requires that the death certificate be executed after death. Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial - transitification: To Re Commisted by Physician/Medical Ex	2:	past 12 months? 4 Pregnant at time of death 5 Other (Specify)	ctopic pregnancy		23d. Date of de Month	lelivery Da	ay Year
J. BC trthe des by the a		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given i	in Part I.	23e. Did tob	acco use contribu	ute to th	ne cause of death?
P.O. es that the iigned by be detach	<u>}</u>			1 Yes	2 🗸 No 3	Proba	ibly 4 Unknown
of Vital Records, ng Physician: The law require. After this certificate has been signeral director, page 2 should be not To Be Completed.	200			24a. Was ar autopsy			opsy findings available impletion of cause of
Reco The lav	<u></u>			perform 1 Y es 2	ned? dea	ath? ✔ Yes	_
tal Recion: The location certificate leector, page	b 2	examiner?	eath (Check only	(Property)		1	
1 of Vi ling Physi After this funeral di	2 2	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at V	T I Italianing Tie		esidence 6	Other:	
ion c tending eath. for: Af the fun	5	1 Natural 5 Pending Mar 1, 2010 0726 hrs 1 ✓ Yes 2	2 No Sub	oject shot			
		2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) Other (Gas Station)		or Town, Sta			al Route Number, City
the Ho hin 24 I the Fu npletely		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and cone) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death and another another stated					
To To To Con	2	29b. Signature and title of certifier 29c. License num			29d. Date signed		h, Day, Year)
		Victor Vatter Week 1 O.C.M.E.			March 4, 201	10	
	3	30. Name and address of person who completed cause of death (Item 23a) Victor Weedn MD JD Assistant Medical Examiner 111 Penn Street, Baltim	more, MD 212	201			
State Registra		31. Date filed (North, Day Year) 32. Registratic Signature 3. parl					
Registra	4	LOID NOTON D. Marie					

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** AM 0105 WHICIA /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Medical N/A HOPKINS Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Hours 1 □ M 2√2 F Months Days Min. 217-30-3701 74 **Director** June 22,1935 Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County Department of Health and Mental Hygiene. Important; or items 23a or 28a-f show Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Wadcal Evar, item rough be notified at another. 10c. City, Town or Location 10d. Inside City Limits Director MD Dunda1k 1 ☐ Yes 2X No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6743 Woodley Road Funeral death v 21222 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ∏Yes 2√ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 汉No Specify: ₽ Specify White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 10 Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ္ Mary J. Chalone Andrew Roy Francis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Parkville, Maryland 21234 Michael A. Phelps (Grandson) 2821 Ontario Ave. altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Hilltop Service Corp. 3/4/2010 □ Donation 5 □ Other (Specify) Towson, Maryland 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk 21. Signature of Funeral Service Licensee 21222 7922 Wise Ave. Dundalk, Maryland 23a: Part 1- Emer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 0 disease or condition resulting in death) ays /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Conditions and Indiana Cause Caus Examiner Due to (or as a consequence of) use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. physician law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy for in the past 12 mont Month Day Year 5 Other (specify) ed by the a o □Yes 2 No 9 Unknown 9 Unknown σ. signed t Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 Probably 4 Vunknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? has 24a. Was an page 2 autopsy performed? certificate 1 ☐ Yes 2 ☐ No 1 □Yes To the Hospital or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No After this c funeral dire 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of Injury 28d. Describe how injury occurred Division s after deau.
ral Director: Aftr 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 T Suicide filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last)
Bertha Sophie Panicho 2. Date of Death 3. Time of Death Physician/ MAYCH 3, 2010 5:55 A. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Westminster Carroll Hospice . Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 V F 89 December 14, 1920 Marviand 220-05-2886 **Director** Usual Residence of Deceden 10c. City, Town or Location Parkville 10d. Inside City Limits 28a-f shov 10b. Count permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 0a. State Director Baltimore Maryland 1 🗆 Yes 2 🗶 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21234 USA 7808 Westmoreland Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🔀 No Specify: If Yes, Give Year or Dates Specify: Completed 3 XWidowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) Augusta Klaas 17. Father's Name (First, Middle, Last) ည Karl Finger 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
9410 Orbitan Court Baltimore Maryland 21234 19a. Informant's Name/Relationship (Type, Print) Donna M. Franchetti/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Moreland Memorial Park 3/5/10 Baltimore Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens 2. Nama and Addrewick Facility 5305 Hartord Road Baltimore Maryland 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, Approximate shock, or heart failure. List only one cause on each line Interval Between and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examiner attending physician and for use as the burial-transit that the death certificate be executed Physician/Medical Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy ☐ Pregnant at time of death 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month signed by the a d be detached f g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown completed filled in by the funeral director, page 2 should Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has 1 Yes 2 No Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 No ᅆ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify After this 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 24 hours after deatle Funeral Director: Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier

DHMH 17 Rev 7/2009

State Registrar 30. Name and address of person who co

31. Date filed (Month, Day,

			1 - State Of I	•	artment of Health and I <i>rtificate of Death</i>	Mental Hygie Reg.	0010	06689
	Physicia	ın/	1. Decedent's Name (First, Middle, Last) Pernell D. Parke	er		2. Date of Death Month 2/23/		3. Time of Death
	Medic Examin		4a. Facility Name (if not institution, give street and number Washington Adventist		4b. City, Town, or Location of Death Tacoma Park		4c. County of Death Montgome	5:40am
	Funeral		5. Social Security Number 6. Sex 7.	Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth		
	Director		241-48-2509 1 ★★ 2 □ F Usual Residence of Decedent	71 Yrs.	World's Days Floors Will.	Month, Day, Ye	938	place (State or Foreign try) NC
	Maryland 28a-f sho otified at	irector	10a. State 10b. County Prince Geo:	10c. City, Town or Lo	Hyattsville		1	0d. Inside City Limits 1
	h with the ns 23a or nust be n	Funeral Director	10e. Street and Number 6800 Highview Terrace	e, Apt 202	10f. Zip Code 20782	10g.	. Citizen of What Cour	usa USA
900	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	2	11. Marital Status 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced 12. Was Deceder Armed Force 1 ☐ Yes 2 If Yes, Give Year or Dates	s? K l No	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 🛣 No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify:	
Baltimore, Maryland 21215-0036	ithin 72 hor ene. r than "nat rhe Medica	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) 12 College (1-4 of the completed)	(Give	dent's Usual Occupation kind of work done during most of work NOT use retired) Supervisor	sing 16t	o. Kind of Business In	tal Service
land 2	l be filed w lental Hygi rked other tic event, t	To Be	17. Father's Name (First, Middle, Last) COLLIE Parker			ne (First, Middle, Maid MCCOY		ar bervice
, Mary	id 2 should saith and M n 27 is ma er traumai		19a. Informant's Name/Relationship (Type, Print) Hattie Tindall / Sister	19b. Maili 9	ing Address (Street and Number or Rur 820 Hilgert Drive	al Route Number, City Clevelan	y or Town, State, Zip (d, OH 44	104
imore	Page 1 an ment of He tant: If iten ury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from Sta 4 ☐ Donation 5 ☐ Other (Specify)		matory or other place)	Date 200 /6/2010	c. Location - City or To Winnabo	
Balt	permit. Depart Import any inj		21. Signature of Poneral Service Licensee Victor	P. Doda 2	Charles L. Stevens 1501 E. Fort Ave.	Funeral BAltimor	Home, Inc. e MD 21230)
	Physician/		23a. Part 1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each I Immediate Cause (Final disease or condition	ed the death. Do not ent in Spin	1	or respiratory arrest,	a	Approximate Interval Between Onset and Death
	Medical Examiner		resulting in death) Due to (or a Sequentially list conditions,	s a consequence of):	<i>V</i>			
	ted I Insit	Examiner	if any, leading to immediate Due to (or a cause. Enter Underlying Cause (Disease or iinjury	as a consequence of):				
	cate be executed physician and the burial-transit	cal Exa	that initiated events resulting in death) Last C. Due to (or a	as a consequence of):				
8760	tificate the place of the place	Medical	IF FEMALE:					
. Box 68	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant 23c. If yes, outcome 1 Live Birtl	h 2 ☐ Fetal death 3 ☐ t at time of death 5 ☐	Ectopic pregnancy Other (specify)		23d. Date of delive Month	ery Day Year
Records, P.O.	uires that the signed by tid be detact	by	Part II. Other significant conditions contributing to death	but not resulting in the u	underlying cause given in Part I.		co use contribute to th	ne cause of death?
Secord	he law req te has bee age 2 shou	Completed	Jangeine Sepsi	J. a Cut	t rinal failu	24a. Was an autopsy performed	prior to co death?	osy findings available mpletion of cause of
ta	Physician: T r this certifice aral director, p	Be	25. Was case referred to medical examiner?		26. Place of Death (Chec		inoj i les	2 🗆 NO
of V	ing Phys n. After this funeral di	ate: To	27. Manner of Death 1 Natural 5 Pending (Month, E		nt 3 DOA 4 Nursing Hof 28c. Injury at work?	ome 5 Residence 28d. Describe how in	e 6 Other (Specify njury occurred)
Division of Vital	l or Attenc after death Director; , d in by the ;	Certificate:		njury - At home, farm, str etc. (S <i>p</i> ec <i>ify</i>)	M 1 ☐ Yes 2 ☐ No reet, factory, office	28f. Location (Street City or Town, St.	and Number or Rural ate)	Route Number,
	ne Hospita n 24 hours ne Funeral pleted fillec	Medical	29a. Certifier (Check 2 Medical Examiner: On the basis or only one) 3 Certifying Nurse Practioner: To the basis or only one)	f examination and/or inves	occured at the time, date and place, ar stigation, in my opinion, death occurred a death occurred at the time, date and pla	t the time, date and pla	ace, and due to the cal	use(s) and manner stated.
	To the within the complete com		29b. Signature and title of certifier	50	29c. License number D45471		Date signed (Month, I	
			39. Name and address of person who completed cause of	death (Item 23a) (Type, F	Print) WiShin	akn ;	Advina	of Hosp.
ļ	Stat Registra		31. Date filed (Month, Day, Year) MAR 0 5 2010 32. Regis	trar's gignature on the		<i>y</i> , .		

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) Day **Physician** 1:45 ARC /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner gnes marc If Under 24 Hrs. If Under 1 Year 8. Date of Birth 4-5-1956 5. Social Security Number 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours 1**X** M 2□ F Months MD **Director** Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c, City, Town or Location 10a. State 10b. County ortant; If item 27 is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, the "No itel Examination at the notified at 1 ☐ Yes 2 🕅 No **Funeral Director** atonsville more 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the "world Extra-1 □ Yes 2 100 lf Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Black 3 ☐ Widowed 4 💆 Divorced ģ Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use reliced) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) vorand Jr: vex 18. Mother's Name (First, Middle, Maiden 17. Father's Name (First, Middle, Last) Be ပ OVO ormant's Name/Relation hip (Type. Print) State, Zip Code) 19b. Mailing Address (Street and Number or Rural te N<u>umb</u>er, City 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition 20c Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ElKridge 21. Signature of Funeran Service Licens File. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or asea consequence of) Examiner Sequentially list conditions, it immediates a cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of : Hospital or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Vital Records," Completed by STORING STORY 3 Probably 4 → Onknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 ₽No 1 □Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **3** No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA of Certification: To After this completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Division 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident after death 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title 29c. License number P24057 313110 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 15altimore, MD rve 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 5 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1:05 Donald Powell JOI Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Washington Med Ctr Anne Arundel Glen Burnie 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Days 1 X M 2 🗆 F Months Hours Min (Month, Day, Y Sept 18 Year Country) unk Director 220-32-7413 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits iral", or items 23a or 28a-f sho Examiner must be notified at Director 1 Yes 2 V No Glen Burnie MD Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7355 Furnance Branch Road 21061 USA death \ 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 72 hours after If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify. white "natural", Specify: 60-63 Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry unk unk (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) unk unk Be 17. Father's Name (First, Middle, Last) unk. 18. Mother's Name (First, Middle, Maiden Surname) unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore Washington Med Ctr 301 Hospital Drive Glen Burnie, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location ~ City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 🛛 Other (Specify) in state Signature of Funeral Service Licensee 22. Name and Address of Facility State Anatomy Board Baltimore, MD 21201 655 W. Baltimore Street Wirector art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death ock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Physician Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Examine Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last burial-trar Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Dav Year Pregnant at time of death Unknown 5 Other (specify) signed by the a d be detached f Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy page perforn death? certificate Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 Suppatient 2 ER/Outpatient 3 DOA

28a. Date of injury
(Month, Day, Year)

28b. Time of injury
injury
28c. injury Other: ၉ 1 Tes 2 X No 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28c. Injury at Certificate: 28d. Describe how injury occurred Natural work? 5 Pending 2 No within 24 hours after death.

To the Funeral Director: A completed filled in by the fu Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature, and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar 30 Name and

oxperson who completed cause of death (tem 23a) (Type, Print)

20/0

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 130 PM POLLOCK 2010 errance /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washing estown Healtho Halestown OVE Hal ear If Under 24 Hrs. 8. Date of Birth (Month, Day, May 18, 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex Age (In yrs. last birthday) **Funeral** 1 X M 2 □ F 75 1934 577-46-7249 Pennsylvania Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County MD 1 ☐ Yes 2√ No Director Washington Hagerstown 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 14014 Marsh Pike 21742 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No If Yes, Give Year or Dates: ¹53–57 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: white Be Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) paramedic/fireman airport 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Robert Pollack Sr Margaret Lillian Eadon 0 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Pollack/brother 1534 E Silver Hammock Deland, FL 32720 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any Injury or once. 4□Donation 5肽Other(Specify) in state 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Wade. Director min Baltimore, MD 21201 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Oause (Final disease or condition resulting in death) mets to liver olon Cancer **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of: Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, the I phy as 1 IF FEMALE asn 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown cate has been signed I page 2 should be det Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? Yes 2 No certificate 1∐ Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certification: To 1 Inpatient 2 ER/Outpatient 3□ DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 25-2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 14014 Marsh Pike M Stown 31. Date filed (Month, Day, Year) 32. Registrar's Signature

Registrar

MAR 0 5 2010

		State of Maryland / Department of Health and I	Mental Hyg	giene	00003
		Registrar Certificate of Death		Reg. No. 2010	06693
Physicia Medio		1. Decedent's Name (First, Middle, Last) James D. Parson	2. Date of Dea Month Feb.	21 ^{Day} 2010 ^{ear}	3. Time of Death 8:01P M
Examin		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death	1	4c. County of Death	-
med .		Southern Maryland Hospital Clinton		Prince Ge	
Funeral Director		5. Social Security Number 6. Sex 1.26-48-5630 1.25 F 7. Age (In yrs. last birthday) 1.26-48-5630 1.25 F 7. Age (In yrs. last birthday) 1.26-48-5630 1.25 F 7. Age (In yrs. last birthday) 1.26-48-5630 1.25 F 8. Age (In yrs. last birthday) 1.26-48-5630 1.26 F 8. Age (In yrs. last birthday) 1.26-48-5630 1.26 F 8. Age (In yrs. last birthday) 1.26 F 8. Age (In yrs. last birthda	8. Date of Birth	9. Birthp	lace (State or Foreign York
_ A		Usual Residence of Decedent			
yland -f shc ed at	ţ	10a. State 10b. County 10c. City, Town or Location		10	Od. Inside City Limits
e Mar r 28a notifi	Director	MD Prince Georges Upper Marlboro 10e. Street and Number 10f. Zio Code			1 X Yes 2 ☐ No
ING Z1Z13-UU30 I filed within 72 hours after death with the Manyland tal Hyglene. ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	rall	10e. Street and Number 6303 Blue Sage Lane 10f. Zip Code 20772		10g. Citizen of What Count USA	try?
eath v tems er mu	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp	pecify Yes or No-	14. Race - America	an Indian,
offer d ", or i	ğ	1 LA Never Married 2 L Married 1 L Yes 2 L No	o Hican, etc.)	Black, White, e	
ours attural	Completed	3 Widowed 4 Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation		Specify: Blac	
715 172 h 3n "na Medik	E I	(Specify only highest grade completed) (Give kind of work done during most of work	king	16b. Kind of Business Ind	ustry
X12 withir rgiene rer tha		Elementary/Seconday (0-12) College (1-4 or 5+) III. DO NOT use retired) 12th Presser		Private	<u> </u>
Maryland 21215-UU30 2 should be filed within 72 hours after death with the Maryland th and Mental Hyglene. 27 is marked other than "natural", or items 23a or 28a-f sho traumatto event, the Medical Examiner must be notified at	To Be		ne (First, Middle, I	•	
Lryle build b d Mer mark matic	[James Ross Magdal 19a. Informant's Name/Relationship (Type, Print) 19b-Meillen Address (Streetend Numberor But		Livingston	
Ma 12 sho alth an 27 is r trau		Brenda Parson/Sister 1903 Nsiling Address Street and Number of Run 1905 Nsiling Address Street and Number of Run 190	refroute Number,	, City or Town, State, Zip Ci 72	ode)
of Hear fittern rothe		20a. Method of Disposition 1 Burial 2 🔀 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Tox	
Page Page ment tant: I		4 Donation 5 Other (Specify) Chesapeake Crematory 2	2/25/10	Beltsvill	e, MD
baltimore, Marylan permit. Page 1 and 2 should be fi Department of Health and Menta Important: If item 27 is marked any injury or other traumatic es		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Au 3821 14th Stree			
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac			Approximate
Physician/	33 S	shock, or head failure. List only one cause on each line. Immediate Cause (Final ACUTE ATHEROSCLERUTIC CARDIOL disease or condition			Interval Between Onset and Death
Medical Examiner		resulting in death) a. Due to (or as a consequence of):	V/11/00/01	J. Blevie	
	e	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
ted Insit	dical Examiner	cause. Enter Underlying Cause (Disease or iinjury			
ate be executed hysician and the burial-transit	EX	that initiated events c. resulting in death) Last Due to (or as a consequence of):			
ate be hysici the bu	dica	d			
ertifica ding p	/We	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			
death co	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1		23d. Date of deliver Month	ry Day Year
the de by the arched	hysi	9 Unknown			
s that the		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		bacco use contribute to the	1
een si	eted		1 L Y	es 2 □ No 3 □ Prob	1
The law requires ate has been signage 2 should b	Completed by	CEREVERAL VALUEDA ACCIDENT	24a. Was a autops perfori	sy prior to con	sy findings available pletion of cause of
n: The fficate or, pag	e Co	25. Was case referred to medical 26. Place of Death (Chec	1 🗌 Yes		No No
vita sicia sicert	To B	examiner? Hospital:		ence 6 Other (Specify)	
g Phy ter this		27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at		ow injury occurred	
VISICII or Attendir frer death. irector: Af	ifica	1 ☑ Natural 5 □ Pending (Month, Day, Year) Injury work? 2 □ Accident Investigation 3 □ Suicide 6 □ Could not be			
- 0 m O	Certificate:	4 Homicide determined determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (St. City or Town	reet and Number or Rural I n, State)	Route Number,
ospita hours Ineral	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and	nd due to the cau	se(s) and manner as stated	.,, ,
the H thin 24 the Fi	Me	(Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred a only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place.	ce, and due to the	cause(s) and manner as state	ted.
5 ≥ 5 0 0 0		29b. Signature and title of certifier DS0689	1	29d. Date signed (Month, D	
<u>5</u>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANILIC MAH	A7 0-01-1	DATTION ON	M'N MADY -
		LAND HUSPITAL CENTER 7503 SURRATTI R	NAD CL	LINTUR 20	735
Stat	e	LAND HUGP) FOL CENTER 7503 SHRRATTS R 31. Date filed (Month, Day, Year) MAR 0 5 2010 LINE S. Jacks			
Registra		MAN VO ZUIU HEREN B. MAN			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month Eugene Francis Redden February 2010 :49 Р Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death Bethesda Vear If Under 24 Hrs. Min. Suburban Hospital Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 🕅 M 2 🗆 F Months Indiana **Director** 317-14-2010 86 January Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Montgomery Bethesda 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? Funeral 20814 6313 Berkshire Drive United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2 No Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify: If Yes, Give Specify. 3 Divorced 4 Divorced Year or Dates. WWII White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Federal Government Nuclear Scientist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Lily Violet Purcell William Andrew Redden 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6313 Berkshire Drive, Bethesda, Maryland 20814 Yasue Redden Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Montgomery Crematorium, Inc. March 4, 2010 | Bethesda, Maryland Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. the other M01360 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Ventricular Fibrillation disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to for as a consequence of: the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year 1 Yes 2 [Pregnant at time of death 5 Other (specify) signed by the a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 💢 No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 performed' 2**X** No 1 Yes Yes 2 N 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 X Natural 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 5 Pending work? 1 ☐ Yes 2 ☐ No ☐ Accident Investigation Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours a Medical 29a. Certifier X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) as, MD DO057124 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ,10110 Molecular Drive #206, Rockville, Maryland 20850 Truong Bao, M.D.

Registrar

State

DHMH 17 Rev 7/2009

32. Registre's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) February 23, 2010 **Physician** 7:55 A M Graciela Ramirez /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Montgomery Silver Spring Genesis Layhill Center If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** February 27, 1912 Months Days Hours Min. Peru 1 □ M 2 🔼 F 220-61-0394 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a Medical Evanting must be notified as 10d. Inside City Limits 10b. County 10c. City. Town or Location 1 ☐ Yes 2 No Bethesda **Funeral Director** Maryland | Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 9401 Cedar Lane 20814 Peru Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Specify: White 1 ☐ Never Married 2 ☐ Married 1½Yes 2□No *Specify*:**Peruvian** Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates Completed by 3 ₩ Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Not Available Not Available ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 12710 Travilah Road, Potomac, Maryland 20854 Leoncio Gutierrez/Son 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) February 27, 1 Burial 2 ☐ Cremation 3 ☐ Removal from State All Souls 2010 Germantown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Robert A. Rockville. Inc. 300 Most Pumphrey Funeral Home/ 21. Signature of Funeral Service Licenses Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850 M01498 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Head and Neck Cancer Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? Pregnant at time of death 5 ☐ Other (specify) 1 □Yes 2 X No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🎦 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed has 1 ☐ Yes 2 ☐ No 1 Tyes 2 X No the Hospital or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 💆 Nursing Home 5 🗆 Residence 6 🗆 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 X Natural 5 ☐ Pending within 24 hours after co...

To the Funeral Director: Aft

To the Funeral Director: Aft 1 Yes investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title D0064208 February 26, 2010 4.0

State Registrar 31. Date filed (Month, Day, Year) MAR 0 5 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Februas, Frances V. Ramsey 2010 6:45 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 9205 Cedarville Road Prince George's Brandywine 9. Birthplace (State or Foreign Country) Washington :DC 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday 8. Date of Birth Funeral (Month, Day, 1 🗆 M 2 🗔 **Director** 213 56 9560 Usual Residence of Decedent or 28a-f show 10a, State 10h County 10c. City. Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at Director MD Prince George 1 ☐ Yes 2 XXNo Brandywine 10f, Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral items 23a 9205 Cedarville Road 20613 United States permit. Page 1 and 2 should be filled within 72 hours after death v Department of Health and Mental Hygiene. Important: if item 27 is marked other than "---- any injury or other than "----13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 XXNo If Yes, Give 1 ☐ Yes 2xx No Specify. Specify: White 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Housewife Home Owner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Lee Kerns Martha Dennison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ernest Ramsey (Son) 9205 Cedarville Road, Brandywine, MD 20613 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗆 Burial 2 🛣 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Lee Crematory 3/2/2010 Clinton, Maryland 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d Alexandria Ferry Road, Clinton, MD 20735 23a. Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final disease or condition Onset and Death CANDVASEG Physician/ Atheroselletic Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Pregnant at time of death 2 No Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 2 No Yes Be (25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 Tes ျှ 2 No 4 Nursing Home 5 Kesidence 6 Other (Specify, 1 Inpatient 2 I ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes 2 No 28d. Describe how injury occurred Natural 5 Pending injury ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my scriptor death. Medical 29a. Certifier 2. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

Registrar
DHMH 17 Rev 7/2009

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

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8	the dea	Physician/M	1 ☐ Yes 2 🔀 No 9 ☐ Unknown	4 ☐ Pregnant at t 9 ☐ Unknown	time of deati	n 5∟	Other (specify)					WIOII	1611	Day II	Cai
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Division of Vital Records, P.O. Box 68	or Atter after des Director in by the	Certificate:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc.		, farm, stre	et, factory, offic	е		28f. Location (City or To			r or Rural	Route Numbe	er,
<i>α</i>	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check 2 Medical Examine	ian: To the best of mer: On the basis of exa	amination and	d/or investi	gation, in my on	nion, death	occurred at	the time, date	and place.	and due	to the cau	ise(s) and mar	nner stated.
19	o the vithin 2 o the omple	Ĭ	only one) 3 Certifying Nurse 29b. Signature and title of certifier	Practioner: To the be	est of my kno	owledge, d		the time, da		ce, and due to the			nner as sta (Month, I		
þ	F S F O		Mari Sen	t, CRNP				49191			Ma				
			30. Name and address of person who cor	npleted cause of dea	ath (Item 23a	a) (Type, P	rint) Suite	4105	ito	Lu 50 A	M	D 2	7170	24	
	Stat		MAR U 5 2010	32. Registrar'	's Signature	1-	4.1		, , , ,					•	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Marie Smith Theda Physician/ March 3, 2010 2:23 A. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Gilchrist Hospice Towson 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday)
58 vrs **Funeral** Months Days 1 M 2X F December **16*** 1951 Director Virgima 214-54-6153 Usual Residence of Decedent 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Jarrettsville 1 Yes 2 No Maryland Harford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21084 USA 3520 Advocate Hill Drive 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Completed by 1 Never Married 2 Married 1 ☐ Yes 2 💢 No If Yes, Give Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2 XNo Specify: 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) 27 is marked other than traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Towson Medical Association Patient Care Coordinator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Nellie Mullens Gardner Randolph Parks, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9396 Hollow Road Felton Pennsylvania 17322 Cheri Lubawski/ Daughter item 2 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of Important: If it any injury or o once. cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Gardens of Faith Baltimore Maryland 3/6/10 4 Donation 5 Other (Specify) Entonbment 22. Name and Address of Facility 5365 Harrord Road Baltimore Maryland 21214 ure of Funeral Service Lice 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between n t and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence of). it any, leaving to immediate cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 Who Day Pregnant at time of death Yes been signed by the sahould be detached g Unknown 9 Unknowh Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an autopsy performed prior to completion of cause of death? has page 2 After this certificate 2 No Yes 1 Yes filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 Yes Hospital: 2 No Other: ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of D + th 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 A Homicide determined 24 hours Medical 🖄 certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hour To the Fune completed file Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifi

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month. 71101 3:40 p^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 10032 Hillgreen Circle AptF Cockeysville Baltimore Co. 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Months Days 1 M 3 F Director 219-52-5591 Maryland 12-27-1948 61 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Wolfall Examinat Trust De rollified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1∏Yes 2XNo Baltimore CO. Cockeysville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10032 Hillsgreen Circle Apt.F 21030 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No ģ If Yes, Give Year or Dates: Specify. Specify: 3 ☐ Widowed 4 ☐ Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5years Telemarketer Telephone Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ John House Dell Blue Rose 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 0 3 0 19a. Informant's Name/Relationship (Type. Print) Ghassan Shah(Husband) 10032 Hillgreen Cir. Apt.F, Cockeysville, MD 20b. Place of Disposition (Name of Cemetery, crematory of other place)
JOSEPH Brown F'H
AND Crematory 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 03/05/10 Baltimore, MD 21. Sign ture of Funeral Service Licensee Joseph H. Brown Jr. Funeral Home 2140 N. Fulton Ave., BAltimore, MD 21217 23a. Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final udden Physician resumed 5 dise so of condition u ting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <u>la</u> Due to (or as a consequence of): law requires that the death certificate be execut∈d Exami signed by the attending physician and I be detached for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 4 Pregnant at time of death 5 ☐ Other (specify) □Yes 2□No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 → No 3 ☐ Probably 4 ☐ Unknown iis certificate has been s director, page 2 should Completed 010 0 Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 1 ☐ Yes 2 ☐ No arcoldosi 1 □ Yes 2 🖼 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral (28a. Date of Injury (Month, Day, Year) To the Hospital or Attending Pleating 24 hours after death.
To the Funeral Director; After the completely filled in by the funeral 27. Manner of Death After t 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1920 atural ∠ □ Accident 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 才 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

0

32. Registrar's Signature

Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

DS1892

J. Charles, Batto

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#1, 2perPHYS, G901, 375/2010, WS
State of Maryland / Department of Health and Mental Hygiene 08 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2/14/2010 Albert H. Sands 3. Time of Death Physician/ Month 9:57 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HEBREW HOME OF GREATER WA MONTEGOMOLY RUCICVILLE If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 6. Sex Days (Month, Day, Year) 8/29/23 1 1 M 2 | I 0.64-18-5485 86 **Director** Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 27 is marked other than "natural", or items 23a or 28a-f s traumatic event, the Medical Examiner must be notified Montgomery Rockville 1 ☐ Yes 2🌠 No MD 10e. Street and Number 6121 Montrose Rd 10f. Zip Code 10g. Citizen of What Country? 20852 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc , or 1 Never Married 2 Married 2 **X** No Completed by 1 Yes 2 1 Yes 2 No Specify: white Specify: 3 🗌 Widowed 4 🗎 Divorced Year or Dates / うのアプログ Baltimore, Maryland 21215-0 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Franchises Business Owner permit. Page 1 and 2 should be filed wi Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, II once. Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Unk. ည Morris Sandrowitz Lena 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leslie Sands / Daughter 01201 2404 Wanda Way, Reston, VA 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Durial 2 Cremation 3 Nemoval from State cemetery, crematory or other place)
Montefiore Cemetery 2/16/2010 St. Albans, 4 ☐ Donation 5 ☐ Other (Specify) r²². Name and Address of Facility
Charles L. Stevens Funeral Home, Inc.
1501 E. Fort Avenue, Baltimore MD 21230 21. Signature Funeral Service LicenseeVictor P. Doda, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between MYOCARDIAL INFARCT Onset and Death Immediate Cause (Final UTE Physician/ disease or condition Medical resulting in death) **Examiner** ONE HOUR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death for use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death signed by the a Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by PHERAL VASCULAR No 3 Probably 4 Unknown page 2 should DIABETES MELLITUS 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performe 2 🗌 No Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 2 Accident injury 5 Pending s after death.

I Director: Aff
id in by the fur 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide completed filled in by determined City or Town, State) 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Physician: To the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifier 018084 nin 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 612, MONTROSE RD ROCKVILLE MO 20852 ATEL PINESH 32. Registrar Signature 81. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 7/2009

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			- For State Registrar			Certific	cate of	Death			R	eg. No.		
	Physicia		tegistrar 1. Decedent's Name (First, Midd	le,Last)			-			2	Date of Dea Month			3. Time of Death
	lical Exami	ner	Christopher	Parker	Smi	th					February 25, 2010 0413 hrs			
			4a. Facility Name (if not institution Johns Hopkins Bayvie	on, give street and n			41	o. City, Town, or L Baltimore	ocation o	of Death		4c. County of	Death	
	Funeral		5. Social Security Number	6. Sex		n yrs. last bi	irthday)	If Under 1 Year	If Unde	r 24Hrs.	8. Date of Bir	th(MM/DD/YYYY)	9. Birth	nplace (State or
	Director		213-19-7737	1XM 2 F	2 F 22 Yrs. Months Days Hours					Min.	in. 09/08/1987 Foreign Country) Mary Land			
	>-		Usual Residence of Decedent		[40	c. City, Tow	n or Locatio							10d. Inside City Limits
	W An		10a. State 10b. County		10	Balti		"						1 X Yes 2 No
	yland 1-f she 1 once	ğ	MD 10e. Street and Number			Dalt.	IIIOLE	10f, Zip Code				0g. Citizen of Wha	at Count	try?
	Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Director	3704 Pratt St	reet				21224	4			U.	S.A.	•
	with the same same same same same same same sam	E -	11. Marital Status	12. Was De		er in U.S.	13. Was	Decedent of Hisp s, specify Cuban,	anic Orig	gin? (Spe	cify Yes or No	14. Race - White		an Indian, Black,
	death or iten must	Funeral		farried Armed I	2 X	No				, Puello K	ican, etc.)			
	after ral",	à		vorced If Yes, Give Ye or Dates:		1 - 1 - 1 d C -		Yes 2 X No		kind of wo	rdr dono	Specify: 16b, Kind of Bus		
	hours natu Exan	<u>8</u>	15. Decedent's Education (Spe Elementary/Secondary (0-12)		1-4 or 5+)			st of working life.				TOD, KING OF BUS	iii tooorii	iddoll y
	36 hin 72 e. than '	Completed	12	College	1-401017			Sales	5			Ret	ail	
	d with	녌	17. Father's Name (First, Middle	, Last)				1	8. Mother	's Name (I	First, Middle,	Maiden Surname)		
	215 be file ntal H rked	Be (Victor Lee	Smith					Rose		1	Schiflet		
	21 nould nd Me is ma	2	19a. Informant's Name/Relations			1						mber, City or Town		
	MC 2 sl alth ar m 27		Rose Mary Smi	th / Moth	ner_	20h Place		E. LOMOS ion (Name of cem			Date Bal	timore,		
	of He	ш	1 Burial 2 Crematio	n 3 Removal	from State	crem	atory or oth	er place)						
	Liment trant:	١.	4 X Donation 5 Other S			Anata		s Registry				Hanove		
	Ball Depart	Ц	21. Signature of Funeral Service	Licensee								ifts Reg		, MD 21076
	Physician		23a. Part I. Enter the disease, or	r complications that	caused the	e death. Do								Approximate Interval
	/Medical		failure. List only one cause Immediate Cause (Final disease	Drobo	ble d	lrug t	oxici	tv						Between Onset and Death
	Examiner		or condition resulting in death)	Due to (or as				- J	_	-				
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as	a consequ	uence of):								
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	68760, certificate be nding physic		23b. Was decedent pregnant in t past 12 months?				=	al death 3	Ectopio	c pregnan	су	Month	D	ay Year
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	S, P.O. B. irres that the de signed by the detached f		Part II. Other significant condi			ut not result	ing in the u	nderlying cause gi	iven in Pa	art I.				he cause of death?
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7	Division of Vital Records, P.O. ospital or Attending Physician: The law requires that thours after death. Ineral Director: After this certificate has been signed by filled in by the funeral director, page 2 should be detaced.	Certification:		uld not be. I		y-Athome, sidenc		t, factory, office bu	uilding, et	tc.	or Town, Baltimo	State)3704 F	E. P	ral Route Number, City ratt St
1)	the Hos hin 24 h the Fur npletely	edical C	29a. Certifier 1 Certifying F	Physician: To the basi	s of examir	nowledge, on nation and/o	death occurr or investigati	red at the time, da on, in my opinion,	ite and pla , death or	ace, and c	due to the cau the time, date	se(s) and manner and place, and d	as state ue to the	ed e cause(s)
	To To con	Mec	29b. Signature and title of certif	and manner	stated			29c. License	e number			29d. Date signe	ed (Mor	nth, Day, Year)
	7		Mluk	randle	MD			O.C.N	И.Е.			February 20	6, 201	0
			30 Name and address of perso Melissa Brassell, MD	Assistant	ledical E	xaminer	111 P	enn Street, B	altimor	e, MD 2	21201			
	S Regis	tate trar	31. Date filed Morth, Day Year	2010 Alex	Baginalican's	Signature	gare							
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		For State Registrar		State of Ma	aryland	•	rtment of F tificate of D		and Me		giene Reg. No	7010)	06702
Disconinin		Decedent's Name (First	st, Middle, Las	t)						. Date of Dea	ath			3. Time of Death
Physicia Medic	al	CAROLY		PRINGS						ebrua:	- 1		_	2111 M
Examin	er	4a. Facility Name (if not in Southern Ma	_				4b. City, Town, or Clinton	Location	of Death			County of De		rges
Funeral		5. Social Security Numbe	er 6. Se		(In yrs. las		If Under 1 Year Months Days	If Under Hours		. Date of Birt	h	9. B	irthpla	ce (State or Foreign
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and show	tor		. County		10c. City,	Town or Loc	ation						10d	I. Inside City Limits
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eath w tems	Funeral	11. Marital Status	1 11111	12. Was Decedent E	ver in U.S.		las Decedent of Hi	ispanic Ori				14. Race - An		
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Menta Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 Never Married 2 Widowed 4 □ I		Armed Forces? 1 ☐ Yes 2 🔀 If Yes, Give	No		Yes, specify Cuba ☐ Yes 2 🔀 No			an, etc.)	ŀ	Black, Wh Specify:	ite, etc B1a	
Maryland 21215-0036 12 should be filed within 72 hours after than and Mental Hygiene. 27 is marked other than "natural", or traumatic event, the Medical Exam	Completed	15.	. Decedent's Ed			16a. Deced	ent's Usual Occup	ation			16b. K	ind of Busines		
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nd 21 filed wit al Hygie d other i	اما	12th 17. Father's Name (First, 1	Middle, Last)			Phari	nacy Tech		er's Name (F	irst, Middle,		feway Surname)		
Maryland should be file n and Mental I is marked o raumatic eve	ပ္	Robert Sp							el Wri					
lary should and N is ma		19a. Informant's Name/P		•			g Address (Street a				_		Zip Cod	de)
e, N and 2: Health Eem 27		Daisy Spring 20a. Method of Disposition		Sister	20h Bla		Julep Ct	. A	ccokee			0607 ocation - City of	or Town	a State
Baltimore, Dermit. Page 1 and Department of Hee Important: If item any injury or othe		1 X Burial 2 Cr 4 Donation 5 D	remation 3 🗆		cer	netery, crem	atory or other place reek Church	Com				mden,		i, otate
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Anysician/ / Medical		disease or condition resulting in death)	-	a. Due to (or as a	conseque	nce of):	cepha	1017a	lhy				-	
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on o	icate	50	Pending Investigation	(Month, Day		injury	work	Yes 2	_	a. Describe i	iow injui	y occurred		
Division of Vital Records, P.O. Box 68760 v. To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Certificate:	3 ☐ Suicide 6 ☐ 4 ☐ Homicide	Could not be determined	28e. Place of Inju building, etc		ie, farm, stre	et, factory, office		28	f. Location (S City or Tou		d Number or F)	Rural Ro	oute Number,
Dispital of cours a neral Diffilled i		29a. Certifier 1 💢 C	Certifying Phys	ician: To the best of	mv knowled	dge, death o	ccured at the time	, date and	place, and c	lue to the ca	use(s) ar	nd manner as s	stated.	
he Hos in 24 th	Medical	(Check 2 \square No only one) 3 \square C	Medical Examine Certifying Nurs	ner: On the basis of ex e Practioner: To the l	amination a	and/or invest	gation, in my opinio	on, death o	ccurred at the	e time, date a	ind place	, and due to th	e cause	e(s) and manner stated. ed.
vith vith con t		29b. Signature and title	of certifier	4	0110		29c. License	e number	2 00 0 0	,	29d. Da	te signed (Mor	ith, Da	y, Year)
		30. Name and address of	allu	cui au /	eath (Item 2	(3a) (Time D	int)	052	499		0	400	/ 0	010
2		ALI RA	H M	AN, MD	10	103	HOSPI	TAI	LDF	SIVE	6-	-06	.L/	NTON
Sta Registr		31. Date filed (Month, Day		32. Registra	r's Signatu	re							VI	DX0 1.32
DHMH 17 Rev 7/20	_	MA	R U 5 20	10 1	- /	190								

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Tanuan ZO10 7821 PM Vera Stone Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince Georges Doctors Hospital Lanham Social Security Number Sex 1 X M 2 □ F If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 7. Age (In yrs. last birthday) April 4 Hours **Director** Wash 579-62-2328 ,1947 62 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Prince Georges New Carrollton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5524 Karen Elaine Drive #719 20784 USA filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify. Specify: Black Baltimore, Maryland 21215-003 3 Widowed 4 X Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 721 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ne any injury or other traumatic event **** (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12th College (1-4 or 5+) Office Manager Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Melvin Stone Ella Johnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
19213 Aquasco Road
Brandywine, MD 20613 19a. Informant's Name/Relationship (Type, Print) Kimberly Campbell/Cousin 20b. Place of Disposition (Name of Cemetery, crematory or other place)
Chesapeake
Crematory 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/18/10 Beltsville, MD 21. Signature of Funeral Service L 22. Name and Address of Facility Austin Royster Funeral Home 3821 14th Street, NW, Washington, DC M00996 23a. Part 1. Enter the disease, or complications that caused the deat shock, or reart failure. List only one cause on each line.

Immediate Cause (Final disease or or indition resulting in death)

Due to (or as a conjecture) o not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Physician Medical Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-tranthat initiated events Physician/Medical P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death g Unknown Other significant conditions contributing to deat but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an After this certificate has page 2 autopsy performed 2 🗆 No 1 Yes 25. Was ase referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မှ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide 1 Yes 2 No Investigation 6 Could not be within 24 hours after death To the Funeral Director: filled in by the 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and tit 29d. Date signed (Month, Day, Year) 1251 MDD 28759 30. Name and address of person who completed cause of osath (Item 23) (Type, Print) 7311 Hanover Parkway, Unit B. Greenbelt, mo, 2010 mD. Bijan Bahmanyar

State

Registrar

31. Date filed (Month, Day, Year)

MAR 0 5 2010

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March Gene She1by Sewell 20ÎÎ 3:06 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 405 Washington Blvd. Glen Burnie Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) 72 yrs. If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Country)
ost Virginia Month, Day, Year, ine 10,1937 1 M 2 K Days Months Hours Director 233-56-7548 June West Usual Residence of Deceden ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important if item 27 is marked other than "natural" any injury or other traumatic event any injury or other traumatic event in the marked other than "natural" and injury or other traumatic event in the marked other than "natural" and injury or other traumatic event in the marked other than "natural" and injury or other traumatic event in the marked other traumatic event in the marked other than "natural" and injury or other traumatic event in the marked other than "natural" and "natural" 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** MD Anne Arundel Glen Burnie 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 405 Washington Blvd 21061 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Force Black White etc. Completed by 1 Never Married 2 Married ☐ Yes 2 🕅 No 1 ☐ Yes 2 🛣 No Specify: If Yes, Give White Specify: 3 Widowed 4 Divorced Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ Charles Ε. Asbury Vennie Stump 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ramonda Heishman / Daughter 256 Poplar Road Millersville, MD 21108 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Glen Burnie, MD 03/08/2010 Glen Hayen Mem. Park 21. Signature of Funeral Service License 22. Name and Address of Facility Singleton Funeral & Cremation Mol357 Services 1 2nd Ave,. SW Glen Burnie, MD 21061 23a. Part 1. Set the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ INI Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 \(\subseteq \text{Yes} \quad 2 \subseteq \text{No} \) Month Dav Year Pregnant at time of death 5 Other (specify) 9. Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy nerform death? 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) ၉ 1 Yes Other 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After of the funeral completed filled in by the funeral completed filled 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State Medical Certifying Physician: To the best of my knowledge Medical/Examiner: On the basis of examination 29a Certifier e, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check and/or live 👡 ation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse 29b. Signature and title MARCH 2010 D00025 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KICHARI 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Physician/ 2010 9:45 P M <u> Helen</u> I. Seifert March Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Parkville Baltimore Oak Crest 9. Birthplace (State or Foreign Year If Under 24 Hrs 8. Date of Birth 7. Age (In yrs. last birthday) Social Security Numbe 6 Sex **Funeral** Days July 11 Months ,1916 1 M 2 X F Maryland 93 Yrs 212-42-5574 **Director** Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Director Parkville Baltimore 1 Yes 2 XNo MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral **USA** death with 21234 2143 Pitney Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates. within 72 hours after Completed by Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 XNo Specify: "natura!", 3 Widowed 4 Divorced traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) filed within 72 al Hygiene. At Home College (1-4 or 5+) Elementary/Seconday (0-12) Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Page 1 and 2 should be fill ment of Health and Mental cant; If item 27 is marked or ပ Valeria Koperska Kucicki Kostanty 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2143 Pitney Road-Parkville, Maryland 21234 19a. Informant's Name/Relationship (Type, Print) Karen Seifert-daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1
Department of
Important: If it
any injury or o 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Mar.5,2010 Dundalk, Maryland Holy Rosary Cemetery 22. Name and Address of Facility 8800 Harford Rd. Parkville,MD 21234 Evans Funeral Chapel and Cremation Services 21. Signature of Funeral Service Licensee KMº endre Faulo 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ End disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or se a consequence of, within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Year Hospital or Attending Physician: The law requires that the death Month Day 4 Pregnant
9 Unknown Pregnant at time of death 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 26. Place of Death (Check only one) Division of Vital 25. Was case referred to medical Other: 2 🗆 📈 ပ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4. Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Author Blud. PARKUILLE ier

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

DHMH 17 Rev 7/2009

10-01720 Mark Randall Seibert Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2010 06706

		1- For State Registrar		Ce	ertificate	of L	Death				Reg. No.			
Physicia		1. Decedent's Name (First, Mid	dent's Name (First, Middle,Last) 2. Date of Death									3. Time of Death		
Medical Examir		Mark Randall	Seibert							Februar				1135 hrs
7		4a. Facility Name (if not institut 10 Hilltop Place	on, give street and n	umber)			City, Town, or L Catonsville	ocation of I	Death		1	County of		nty
Funeral	╗	5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday	0	lf Under 1 Year	If Under 2	24Hrs.	8. Date of	8irth(MM/	/DD/YYYY		place (State or
Director	- 1	216-90-3419	1 X M 2 F	47		Yrs.	Months Days	Hours	Min.	ec.	17, 1	1962	Foreigr Cou	ntry) MD
	ŀ	Usual Residence of Decedent												
' any		10a, State 10b, County		10c. City	y, Town or Lo									10d. Inside City Limits
and show	ы	MD	Baltimore		Cat		ville							1 Yes 2 X No
ne Maryland or 28a-f show any Ged at once.	Director	10e. Street and Number				1	l0f. Zip Code				10g. Citi	zen of Wh	at Coun	try?
3a or	₫	10 Hilltop	Place				21228				US.	A		
eath with the items 23a	era	11. Marital Status 1 X Never Married 2	12. Was De Married Armed F	cedent Ever in to Forces?	J.S. 13.		Decedent of Hisp specify Cuban,				No-	14. Race White		an Indian, Black,
or dear	Funeral		1 Yes	2 X No			es 2 X No	enocific				Specify:	Whit	e
rs afte ural"	<u>a</u>	15. Decedent's Education (Sp	or Dates:		16a, Dece		Usual Occupation		nd of wor	k done	16b. F	Kind of Bus		
2 hou "nat	ompleted	Elementary/Secondary (0-12		1-4 or 5+)			t of working life.							
)36 thin 7 re. than	힐		2		Owne	r/0	perator				La	ndsca	nig	Q
5-00 ed wi Hygier other	ड़ो	17. Father's Name (First, Middle		• •	1 0 1122	<u>- / y</u>		8.Mother's	Name (F	irst, Middle				
21215-0036 wild be filed within 77 Mental Hygiene. marked other than c event, the Medical	a	Edward E. Se						Mildre			_			
D 21 hould nd Me is ma	P	19a. Informant's Name/Relation	ship (Type, Print)		1.0	•	ddress (Street							Zip Code)
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 33s or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	-	Mildred Seibe 20a. Method of Disposition	rt Mo	other			1top P1a			nsvil Date				Fown, State
or He of He true		1 Burial 2 Crematic	on 3 Removal i	rom State	crematory of	r other	place)	- ^					•	,
imer Pag ment tant:	1	4 Donation 5 Other		L.			ark Cem	r				odlav		
Balti permit. Departi Import	4	21. Signature of Funeral Service	Licensee	1,0	F	une	ral Hom	of Facility	Cato	nsv <u>i</u> l	le,	Inc.	iwab	WILZKE
	\dashv	23a. Part I. Enter the disease, of	or complications that	caused the deat	1	630	Edmond	son A	venu	e; Ga	itons	$\Delta TTTG$, M	D 21228 Approximate Interval
Physician Wedical	Į	failure. List only one caus	e on each line.							,	·		100	Between Onset and Death
Examiner		Immediate Cause (Final diseas or condition resulting in death)		a consequence		LOVE	sical I	Istul	.a				_	
		Sequentially list conditions,	b											
	ner	if any, leading to immediate	er	a consequence	of):									
1.	Examine	(Disease or injury that initiated events resulting in death) Last	C.	a consequence	of):	_								_
760, cate be executed physician and the burial - transit	9		d					_						
e exectan a	/Medical	X UNPENDED	AMENDED	23a.27.	per N	4Ε s	3901 3/1	6/10	тт					
760 icate b i physi	Ř	IF FEMALE: 23b. Was decedent pregnant in		outcome of pre	gnancy						230	d. Date of		
68 certifi nding se as		past 12 months?	LIVE	birth nant at time of c			death 3 (Ectopic p	regnanc	У		Month	D	ay Year
30x death le atte	Physiciar	1 Yes 2 No 9 U	nknown 9 Unkr		3 [Otne	(Specify)							
of the of the tached		Part II. Other significant cond	itions contributing	to death but not	resulting in t	he und	lerlying cause gi	ven in Part	l.			_		he cause of death?
res th	d b									1 1	es 2 ⊌	No 3	Prob	ably 4 Unknown
rds requi	ete									24a. Wa	as an opsy			opsy findings available ompletion of cause of
e law te has	Completed							-		per	formed?		eath?	s 2 No
I Re	ပ္မ	25. Was case referred to medic	al				26.Place	of Death (C	heck onl					
Vita ysicia nis cei	B O	examiner? 1 ✓ Yes 2 No	Hospital: 1	Inpatient 2	ER/Outpat	tient 3	3 DOA	Other 1	Nursing I	Home 5	Reside	ence 6 🗸	Other:	Scene
of Vital Records, P.O. Box 68 ling Physician: The law requires that the death certif After this certificate has been signed by the attending funeral director, page 2 should be detached for use as	-1	27. Manner of Death	28a. Date (Mon	e of Injury th, Day,Year)	28b. Time	of Inju	, I	y at Work?	- 1	3d. Describ	e how inju	ury occurre	ed	
ion tendin eath.			nding estigation				1_ Y	es 2 N	lo					
ivisior I or Attencather dather death	ij	3 Suicide 6 Co	uld not be 28e. Pla	ce of Injury - At	home, farm,	street,	factory, office bu	uilding, etc.	28	or Town		and Numbe	er or Rur	al Route Number, City
Ospital hours a uneral I	Certification:	4 Homicide	ermined (Specify						- M					
Division of Vital Records, P.O. Box 68760, within 24 hours after death. To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans	edical	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the becaminer:On the basis	est of my knowle of examination	dge, death o and/or inves	ccurre tigation	d at the time, dat n, in my opinion,	te and place death occu	e, and du urred at th	ue to the ca ne time, da	ause(s) an te and pla	nd manner ace, and d	as state ue to the	d cause(s)
To T	Med	29b. Signature and title of certing	and manner fier	stated			29c. License	number			29d.	Date signe	ed (Mon	th, Day, Year)
	=	m C)(O.C.N	Л.E.			Feb	ruary 28	3, 201	0
1		30 Name and address of person	on who completed cal	use of death (Ite	m 23a)									
X		Donna M. Vincenti, M		Medical Exa		111 F	Penn Street,	Baltimor	e, MD	21201				
St	ate	31. Date filed (Month, Day, Yea	r) 32. F	Registrar's Signa	iture									
Regist	rar	MAR 0 5 2010	Centra	1 1.	Barke	_								

10-017	726	3
Alfred	E.	Satti

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible 2010 05707 State of Maryland / Department of Health and Mental Hygiene

		1- For State Certificate of Registrar	f Death	Reg	g. No.			
Physici	Sician/ 1. Decedent's Name (First, Middle, Last) 2. Date of Death Mostly Day Vest							
ledical Exami	ner	Allied B. Batti		February 2	7, 2010	1520 hrs		
		Saa. Facility Name (if not institution, give street and number) 308 Lambeth Road	4b. City, Town, or Location of Deat Catonsville	h	4c. County of Death Baltimore Cou			
F		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hr	s 8 Date of Birth	(MM/DD/YYYY) 9. Birt			
Funeral Director			Months Days Hours Min	_	Foreign	n		
		216-86-3477 1 M 2 F 36 Yrs		reb. 1	2, 19/4 600	antry) MD		
any		10a. State 10b. County 10c. City, Town or Locate	ion			10d. Inside City Limits		
	L	MD Baltimore Catonsv	ille			1 Yes 2 X No		
Aaryland 28a-f show 1 at once.	cto	10e. Street and Number	10f. Zip Code	100	g. Citizen of What Coun	try?		
5-0036 led within 72 hours after death with the Maryland tygiene whatural", or items 23a or 28a-f she the Medical Examiner must be notified at once.	Director	308 Lambeth Road	21228		USA	•		
with t			Is Decedent of Hispanic Origin? (S	pecify Yes or No-	14. Race - Americ	can Indian, Black,		
leath	Funeral		es, specify Cuban, Mexican, Puerto		White, etc.			
after d	by F	3 Widowed 4 Divorced If Yes, Give Year or Poles:	Yes 2 No specify:		Specify: Wi	nite		
ours a atura	g p	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent during the following	nt's Usual Occupation (Give kind of		16b. Kind of Business/Ir	ndustry		
5-0036 led within 72 hou Hygiene. other than "nat	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	ost of working life. DO NOT use ref	area)				
0036 within 72 iene. er than Medical	Ĕ	12	lder		Construct	Lon		
		17. Father's Name (First, Middle, Last) Alfred Edward Satti, Sr.		e (First, Middle, Ma	·			
21215-0036 Muld be filed within 7 Mental Hygiene. marked other than c event, the Medica	o Be			e Physio		~ · · · · · · · · · · · · · · · · · · ·		
O & D & E	ř		Address (Street and Number or Small Court; Cat			Zip Code)		
ore, MC es 1 and 2 s of Health an If item 27			ition (Name of cemetery,		20c. Location - City or 1	Fown, State		
Baltimore, Department of Hea Important: If iter		1 X Burial 2 Cremation 3 Removal from State crematory or oth		5/2010	Baltimore,	MT		
Baltimo permit. Page Department o Important; injury or ott		4 Donation 5 Other Specify:						
Ba Perm Depa Impe	J	Fu	lame and Address of Facility 16 neral Home of Ca	tonsvill	e, Inc.	D 21220		
Physician		00 19 11 5 10 10 10 10 10 10 10 10 10 10 10 10 10	30 Edmondson Ave			Approximate Interval		
\ /Medical		23a. Fart I. Enter the dramse, or complications that coursed the death. Do not enter the failure. List only one cause on each the thadone	on and according to	20		Between Onset and Death		
Examiner		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	on and cocarne u	56				
		Sequentially list conditions, b						
	Je l	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause						
,	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):						
ansit d		d.						
760, icate be executed g physician and the burial - transit	edical	X AMENDED 23a, perm, E G90		O TT				
68760, certificate be anding physicis	. ⋝ I	23a,27,28a-f,pet	rme, gyul 3/11/1	0 11	23d Date of delivery			
687 ertific ding p		past 12 months?	tal death 3 Ectopic pregna	ancy	Month Da	ay Year		
Box 68 e death certif the attending ed for use as	sic	1 Yes 2 No 9 Unknown 9 Unknown	ner (Specify)					
the do	Physician	Part II. Other significant conditions contributing to death but not resulting in the u	inderlying cause given in Part I.	23e. Did toba	acco use contribute to the	ne cause of death?		
cords, P.O. Box 68' law requires that the death certifi has been signed by the attending	څ	· ·	, , ,	1 Yes	2 No 3 Proba	ably 4 🗸 Unknown		
ds, equire	Completed			24a. Was an	24b. Were auto	opsy findings available		
COF law r has b	힐			autopsy perform		mpletion of cause of		
Re The ficate	ै			1 ✓ Yes 2	No 1 ✓ Yes	2 No		
Division of Vital Records, tal or Attending Physician: The law requires after death. al Director: After this certificate has been siled in by the funeral director, page 2 should the funeral director, page 2 should the funeral director.	a	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 FR/Outpatient	26 Place of Death (Check 3 DOA Other Nursin		:1 0 0			
f Vi	의	1 Yes 2 No Investment 2 ER/Outpatient 2 ER/Outpatient 27. Manner of Death 28a. Date of Injury 28b. Time of Ir		28d. Describe ho	esidence 6 🗸 Other:	Scene		
n of Niding Phy. H. After tl	<u></u>	1 Natural 5 Dending (Month, Day, Year)	1 Vas 2 X No	unk	w mjury occurred			
Division pital or Attene ours after death teral Director: filled in by the	Certification:	2 Accident Investigation Fd 2/2//10 Fd 3:10) hiii	28f Location (Str	eet and Number or Rura	al Poute Number City		
Divi	튑	Suicide Could not be determined (Specific) house	st, ractory, office ballaring, etc.		eet and Number of Rura te 308 Lambet ille, MD	h Rd		
c Hospit to 24 hour e Funeri	ల్ల	29a. Certifier A Continue Physician To the heat of multiple death again.	red at the time, date and place, and			,		
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	edical	one) 2 Medical Examiner: On the basis of examination and/or investigation						
To the within To the compl	ğ	and manner stated. 29b. Signature and title of certifier	29c. License number		29d. Date signed (Mont	h, Day, Year)		
		Showed Durthall and	O.C.M.E.		February 28, 2010			
2	1	30. Name and diddress of Jerson who completed cause of death (Item 23a)						
V			1 Penn Street, Baltimore, M	MD 21201		N.		
St	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature			<u>-</u>			
Regist		MAD OF TOTAL	,					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#@) B, C, PERFH, G901, 379/20 (1) WS

State of Maryland / Department of Health and Mental Hygiene 2 | | | | Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Maken 645AM Year JAMES EDWARD TURNER JR. 4c. County of Death Medical 4a. Facility Name (if not institution, give street and number)

VA MARYLAND HEALTH CARE 4b. City, Town, or Location of Death Examiner SYSTEM PERRY POINT 8. Date of Birth (Month, Day, 03/13/19 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. JAMES **Funeral** 1 M 2 □ F Hours 212-20-3182 IRGINIA Director 113/1927 Usual Residence of Decedent 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10b. County Director 1 Yes 2 No BALTIMORE MD 10e. Street and Number 10g. Citizen of What Country? Completed by Funeral U.S.A. 21215 EDGEWOOD ROAD 12. Was Decedent Ever in U.S.
Armed Forces?
1-₹ Yes 2 □ No 12 /1945
If Yes, Give
Year or Dates. 9 /19 46 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married PHYSICIAN: Baltimore, Maryland 21215-0036 1 Tes 2 No Specify: Specify: BLACK 3. Widowed 4 ☐ Divorced 15. Decedent's Education 16b. Kind of Business Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) TRANSPORTATION Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ TURNER SR. JAMES EDWARD PheBA FOUNTAIN AME KNOWN TO 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4048 EDGEWOOD RD., BALTIMORE, MARY And SON ALLEN TURNER position (Name of certain of the place)

To rest VA Certain / 17/2010

Position (Name of certain of country)

Wills, Maryland of the place of facility The DERRICK C. Jones Evelin, P.A. 20b. Place of Disposition (Name of Garrison Forest VA Cem 3/17/2010 20a. Method of Disposition 1. Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 4611 PARK HGTS. AUE., BALTIMORE, MARYLAND 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ischemic Heart Disease Physician disease or condition resulting in death) Vecis Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cauce. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami physician and s the burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical requires that the death certificate be P.O. Box 68760 the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Veal Day 4 Pregnant : 9 Unknown Pregnant at time of death 5 Other (specify) been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Records, After this certificate has been funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? e Hospital or Attending Physician: The I. 24 hours after death.

Funeral Director: After this certificate h. 1 Yes 2 No 1 ☐ Yes 2 No Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Hospital 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury 1 Natural work? 1 ☐ Yes 5 Pending To the Hospital or Attendir within 24 hours after death.
To the Funeral Director: At completed filled in by the fu 2 🗌 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29c. License number 29d. Date signed (Month, Day, Year) March 2, 2010 140054439 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VA Maryland Health - Perry Pound, MAKyland Vincenta giminaro Do 31. Date filed (Month, Day, Year) State barker Registrar MAR 0 5 2010 DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** Peggy 9:00 A M Taylor 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Randallstown attimore Seasons HOSPICE If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 ☐ M 2 ☐ Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside Pity Limits 10a State 10h County 10c. City, Town or Location ral", or items 23a or 28a-f show Examinar must be notified at 1 Ses 2 No Funeral Director yary and 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ Do If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. 2 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Laborer 18. Mother's Name (First, Middle, Maiden Surname) Be Mattie Marsi 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code), 2,213 Informant's Name/Relationship (Type, Print) Baltimore Marian Drive Bur 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages Department of Important: If it any injury or o once. 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee-Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Immediate Cause (Final Atheroscierotic Cardiovascular Disease Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Tue to for as a pensequence off or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) signed by the a ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed/ has 2 🗆 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 4 Nursing Home 5 Residence 6 Dother (Specify) Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No within 24 hours after death.

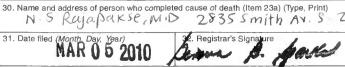
To the Funeral Director: A investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registrar

31. Date filed (Month. Day, MAR 0 5 2010

115 Kyapaksem.D

29b. Signature and title of certifier



29c. License number

203

DO057465

29d. Date signed (Month, Day, Year)

Baltimore, MD. 21209

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2010

The state of the s		Physic /Medi Exami	cal
		uneral irector	
	with the Maryland	a or 28a-f show by notified at	Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner rust be restlined at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.

Division of Vital Records, P.O. Box 68760,

_	for State Registrar			Certificate of		Re	g. No2 0	10 06710			
n	1. Decedent's Name (First, Middle, Las					2. Date of Death Month	Day	3. Time of Death			
al	Lillian Wall		ford			March		$8:15 \text{ A}^{\text{M}}$			
r	4a. Facility Name (If not institution, give				or Location of Dea	th	4c. County				
	406 Beach Side D			Stevens				Anne's			
	5. Social Security Number 6. Sex 1 ☐ M 2 ☑ F 80			nday) If Under 1 Year Months Days			Year) 929	9. Birthplace (State or Foreign Country) New York			
ŀ	Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town	or Location				10d. Inside City Limits			
5	MD Queen A		1 X Yes 2 □ No								
<u> </u>	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?										
<u>=</u>	406 Beach Side D	rive		2166	56		U.S.A.				
₽	11. Marital Status	r in U.S.	13. Was Decedent of If Yes, specify Cul	Hispanic Origin? (ce - American Indian, ick, White, etc.					
. y	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🔀 Divorced		1 □Yes 2 🛣 No		,,	Specif					
be Completed by Funeral Director	15. Decedent's Ed (Specify only highest gra	de completed)		Decedent's Usual Occu (Give kind of work done life, DO NOT use retire	during most of wo	6b. Kind of B	Kind of Business/Industry				
Ē	Elementary/Secondary (0-12)	College (1-4or 5+)		Administra	tion		Gover	nment			
5	17. Father's Name (First, Middle, Last)					me (First, Middle, M					
		allace			Gaynell	Joseph	ine	Lunsford			
2	19a. Informant's Name/Relationship	Type Print)	106	Mailing Address (Stree							
1	Cecelia Caito /		1/								
1	20a. Method of Disposition			6 Beach Sid				- City or Town, State			
	1 ☐ Burial 2 ☐ Cremation 3 ☐	Hemovai from State		Disposition (Name of crematory or other pla		1					
	4 ☑ Donation 5 ☐ Other (Specify	1)	Anatany	Gifts Regist				er, Maryland			
	21. Signature of Funeral Source Uce	see				•	tomy Gifts Registry				
1	1 500			7522 Conr	elley Dr	., Ste. P	, Hano	ver, MD 21076			
	23a. Part 1. Enter the disease, or comp shock, or heart failure. List only	dications that caused the	death. Do no	ot enter the mode of dy	ing, such as cardia	c or respiratory arre	st,	Approximate Interval Between			
	Immediate Cause (Final	Jagos on Jaon IIIIG.	1 1	ma cana	0.			Onset and Death			
	disease or condition a. LOVII COVICE (STANDARD) a. STANDARD (STANDARD)										
	Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate autoc. Enter Unionlying Due to (or as a consequence of): Due to (or as a consequence of):										
5											
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	that initiated events c										
		, d									
	IF FEMALE:	23c. If yes, outcome of p	regnancy				004 5	ate of deliver:			
	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown		ate of delivery Ionth Day Year								
	Part II. Other significant conditions of	ntribute to the cause of death?									
		s 2 No	3 Probably 4 Unknown								
		Were autopsy findings available prior to completion of cause of death?									
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	25. Was case referred to medical examiner?	Hospital:			her-	eath (Check only one					
. 1	I les 213/10	1 🗆 Inpatient		patient 3 DOA	4 🗆 Nursing						
	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day, Ye	<i>ear)</i> 28b. Ti	jury Wo		28d. Describe ho	w injury occu	ileu			
		2 Accident investigation M 1 Yes 2 No									
	3 Suicide 6 Could not be determined 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office City or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State)										
	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)										
	▶ J. Lecouil, 40 D19838 3/3/201										
		D. Name and address of person who completed cause of death (Item 23a) (Type, Print) Strayt F. Sclonick up 900 Bestgate Rd. Annapolis, und 21401									
	31. Date filed (Month, Day, Year)	32. Registrar's	Signature .	100	V.,						
	MAR 0 5 2010	Dence	1. 4	arked.							

Registrar

State

		For State	State of	Marylan	•	artment of F		,	giene Reg. N.20	10	06711		
Registrar 1. Decedent's Name (First, Middle, Last)							2. Date of Dea	tte of Death 3. Time of Death					
Physicia /Medic		ARNOLD	CLIFF	ORD	TAYLO	R		Month February	27, 20	Ye ar)]()	6:00 A M		
Examin	- 1	4a. Facility Name (If not institution, give	street and numb	per)		4b. City, Town, o	r Location of Deat	h	4c. County of Death				
		4237 Hill Lane				Crisf				rset			
Funeral Director		5. Social Security Number 6. Social Security Number 1234-72-1381	ex K∏M2□F 7.	Age (In yrs. 63	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		1946	Coun	place (State or Foreign htry) Virginia		
D		Usual Residence of Decedent					<u> </u>	1					
arylar show	'n	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 □ Yes 2 ☒ No											
the M 28a-f	Director	MD Somerse	<u>t</u>		Crisfi	eld 10f. Zip Code			10g. Citizen of	What Coun			
3a or	Funeral Di	4237 Hill Lane					21817		1	USA	,		
death		11. Marital Status	12. Was Decede		S. 13. \			Specify Yes or No-	- 14. Rac	ce - Americ			
be filed within 72 hours after death with the Maryland tall Hygiene. Ital Hygiene. do other than 'natural', or items 23a or 28a-f show event, the 'nadical Eventine' in ust be notified at	by Fu	1 Never Married 2 Married	1 □Yes 2 If Yes, Give	X No	1	l∐Yes 2∭X No	Specify:	to Filoditi, Otoly	Specif		ite		
hours tural		3 ☑ Widowed 4 ☐ Divorced 15. Decedent's Ed							16b. Kind of B	usiness/Inc	dustry		
e. In "na Medic	Completed	(Specify only highest grade Elementary/Secondary (0-12)	(Specify only highest grade completed) (Give kind of work					rking					
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be filk ntal H ed oth even	Be	17. Father's Name (First, Middle, Last)				unk		me <i>(First, Middle,</i> sta Elle					
should nd Me mark matic	은	19a. Informant's Name/Relationship (7	Type, Print)		19b. Mailin	ng Address (Street					Code)		
alth al		Candace Taylor/d	aughter		4237	Hill Lan	e Crisfi	eld, MD	21817				
es 1 a of He of He if item		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from St	1 /	Place of Dispo semetery, cren	sition (Name of natory or other place	ce)	Date	20c. Location	- City or To	wn, State		
t. Pag tment tant: jury c		4 Donation 5 Dotner (Specify) in sta	te			1						
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if fiem 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Madical Evention in ust be notified at once.		21. Signature of Funeral Service Licen Ronald S	Wade, Dj	rector	I	Name and Addre			Baltim	ore S	treet		
		23a. Part Enter the disease, or implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Approximate Interval Between											
Physician		Immediate Cause (Final disease or condition Onset and Death (Sease or condition) Onset and Death (Sease or condition)											
/Medical Examiner	resulting in death) Due to (or as a consequence of):												
	er	Sequentially list conditions,	b. Due to for	as a conseq	uence offr								
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certifi nding ise as	Physician/Me	IF FEMALE:	23c. If yes, outco	me of pregna	ancy				23d. Da	ate of delive	erv		
death e atte	icia	23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 1 ☐ Yes 2 ☐ No 9 ☐ Unknown							Month Day Y				
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he law e has	Completed								24a. Was an autopsy performed? 24b. Were autopsy findings av prior to completion of cau death?				
an: T	Be Co	25. Was case referred to medical		26. Place of Death					1 \(\text{Yes} \) 2 \(\text{No} \) 1 \(\text{Yes} \) 2 \(\text{No} \) \(\text{Check only one} \)				
nysici nis cel direc		examiner? 1 ☐ Yes 2 ☑ No	Home 5 Residence 6 ☐ Other (Specify)										
ing PI	Certification: To	27. Manner of Death 1 Natural 5 Pending (Month, Day, Year) 28a. Date of Injury (Month, Day, Year) 28b. Time of longury at Work? 28c. Injury at Work?											
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l or A after Direc	ertif								City or Town, State)				
To the Hospital or Attending Physician: The law requires that the death certification 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending to completely filled in by the funeral director, page 2 should be detached for use as	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
To th within To th comp	Me	29b. Signature and title of certifier				29c. Licens	se number		29d. Date signe	ed (Month,	Day, Year)		
		16/10 D-57613 5/1/2010											
		30. Name and address of person who a	s un	0	2016	erint)	refruse	Offer	Sfrele	D, n	B1817		
Sta Registr		31. Date filed (Month, Day, Year)	32. Reg	gistrar's Slona	ature	2	•						
Registr	वा	MAR 0 5 2010	Cener	10.	4								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 00:15 AM Marie Dolores Urban 2010 ما /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Kosed HOSDITal 0 IMORK eucis-e Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min. 1□ M 2√ F Months Days Hours 212-09-7019 Director May 20,1919 Maryland Usual Residence of Decedent 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Essex MD Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number or items 23a or 307 Riverside Road Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify ģ Specify. 3₺ Widowed 4 Divorced 'natural" White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filled within Department of Health and Mental Hygiene. Important: If item 27 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Own Home 8 Years Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Emilie L. Mraz or other traumatic ပ Joseph A. Melka 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1780 Cosner Road Forest Hill, Maryland 21050 Carole R. Linthicum (Daughter) Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 Removal from Staff Injury o 4 ☐ Donation | 5 ☐ Other (Specify) Holy Redeemer Cem. 3/1/2010 Baltimore, Maryland 21. Signature of Funeral Service Lice 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 0 21222 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the disease, or complications that caused the de th. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Monto disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 C Ectopic pregnancy Month Year in the past 12 months? Day Pregnant at time of death 5 Other (specify) 1 □Yes 2 ☑No the 9 I Inknown 9 Unknown Ś Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 🗌 No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform 2 No 1 ☐ Yes 2 ☐ No 1 TYes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes 1 Minpatient 2 ER/Outpatient 3 DOA Certification: To After this 27. May er of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide e Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical within 2 and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 02.26. Kes00000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sann 9000 100 Square Sathish 31. Date filed (Month, Day, Year) State Registrar

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		State of Maryland /		artment o				20	110	06713	
Physici	on/	Registrar 1. Decedent's Name (First, Middle, Last)	Cei	incate C	or Deat		2. Date of Dea	Reg. No 🛴 💄	Year	3. Time of Death	
Med	ical	JOHN E. UPTON					Ø ₂ Month	26	10	1:55P M	
Exami	ner	4a. Facility Name (if not institution, give street and number) 296 Riverside Drive		4b. City, Town, or Location of Death Pasadena				4c. Coun	nde1		
Funera Director		5. Social Security Number 6. Sex 7. Age (In yrs. last bir 220–36–7353	thday) Yrs.	If Under 1 Y Months D	ear If Ur ays Hou	nder 24 Hrs. urs Min.	8. Date of Birt May 1 Day	h (1938	9. Birthp Count	lace (State or Foreign	
	1.	Usual Residence of Decedent 10a. State 10b. County 10c. City, Tow		etian						0d. Inside City Limits	
farylan 3a-f sh ified a	ecto		sade						"	1 ☐ Yes 2X No	
n the M aor28 benool	ρ	10e. Street and Number	, ac	10f. Zip Co	de 21122		T	10g. Citizen of	What Coun	try?	
ath with	Funeral Director	296 Riverside Drive 11. Marital Status 12. Was Decedent Ever in U.S.	e Drive 21 12. Was Decedent Ever in U.S. 13. Was Decedent of					USA	ice - America	on Indian	
fter der fter der , or ite	þ	1 □ Never Married 2 ☑ Married Armed Forces? 1 ☑ Yes 2 □ No	If	Yes, specify (Cuban, Mex	kican, Puerto F	Bla	ack, White, e y: whit	etc.		
2-003 Phours aff "natural", dical Exar	eted	3 Widowed 4 Divorced Year or Dates.	1 ☐ Yes 2 🛣 No Specify: a. Decedent's Usual Occupation						16b. Kind of Business Industry unk		
AID lin 72 h le. han "n hadij	Completed	(Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+)	(Give kind of work done during most of working life. DO NOT use retired) self employed					Tob. Kind of Business industry CITA			
d A I	Be C	12 0	se	elf emp			(First, Middle,	Maidan Surnan	noi		
yiand Id be filed Mental Hy arked ott	101	John Edmond Upton					resa St		ie)		
d 2 should alth and 1 27 is me er traume		19a. Informant's Name/Relationship (Type, Print) Penny Upton/spouse 21	b. Mailin 96 R	g Address (St. .iversi	reet and Nu de Dr	imber or Rural ive Pa	Route Number sadena,	, City or Town, MD 2]	State, Zip C . 122	code)	
DAILITIOTE, IMIGITISIDE A LAID-UUSO permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show my injury or other traumatic event, the Medical Examiner must be notified at ance.				sition (Name o natory or other		D	ate	20c. Location	- City or To	wn, State	
permit. Depart Depart Import any inj		21. Signature Euneral Space Louise Warde Birector		tatendA altimo		-	1 655 W	. Balti	.more	Street	
		23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.									
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Examiner											
ed nsit	Examiner	Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or imjury	of as a consequence oi).								
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ate be	edical	d									
certific ending use as	an/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 □ Live Birth 2 □ Fetal deat	h 2	Estapia proc	nanov			23d. D	ate of delive	ery	
that the death certificate be executed that the death certificate be executed ned by the attending physician and detached for use as the burial-transit	Physician/Mec	in the past 12 months? 1	4 Pregnant at time of death 5 Other (specify) Month								
Attending Physician: The law requires that the death certificate be executed at death. ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transi	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the significant conditions contribute to the significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1									
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ysician: The is certificate director, pag	To Be	25. Was case referred to medical examiner? 1									
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Attend	Certificate:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, fa	arm, stre		1 ☐ Yes 2	-	8f. Location (S	treet and Numi	per or Rural	Route Number,	
tal or value and training after the led in t		building, etc. (Specify)					City or Tow				
To the Hospital or Attendia within 24 hours after death. To the Funeral Director: Al	Medic	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
To t with To t		29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)									
		30/Name and address of person who completed cause of death (Item 23a) (Type. Print) SUSAN H. KKKEGER MD 445 DELENSE Hory Annapolis, MD 21401									
Sta Registr		31. Date filed (Month, Day, Year) MAR U 5 2010	par	N.		/	7	,			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 30 PM February Haydee Vando 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner ose 301 ltosbita 5. Social Security Number 11/10/e 9. Birthplace (State or Foreign Country) San Juan Puerto Rico If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday **Funeral** 8. Date of Birth (Month, Day, Year) Days 1 □ M 2 🗓 F Months Hours Min Director 580-86-9760 95 December Usual Residence of Decedent 10b. County show 10a. State 10c. City. Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 XNo Director 28a-f Baltimore Md. Perry Hall 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 23a 9314 Indian Trail Way 21128 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No or items, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married Maryland 21215-0036 Yes. Give 1X Yes 2 □ No Specify:Puerto Rican White þ Specify. 3 Widowed 4 Divorced Year or Dates: than "natural" Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within 7 nent of Health and Mental Hygiene. ant: If Item 27 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) 12 U.S. Government <u>Secretary</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Julia Barredo ပ Vando Erasmo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DTR. 9314 Indian Trail Way Perry Hall, Md. 21128 Ingrid F. Chelevitte permit. Pages 1 and Department of Healt Important: If Item 27 any injury or other 1 once. **Baltimore**. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2-26-2010 Balto. Md. Bayview 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home Bur G. 9705 Belair Rd. Nottingham, Md. 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or * a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical as the l IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4 ☐ Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 ☐No the detached 9 Unknown 9 Unknown cate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 2 No 1 □Yes 1 ☐ Yes 2 ☐ No funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \subseteq Nursing Home 5 \subseteq Residence 6 \subseteq Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of After t al or Attending P s after death. I Director: After i d in by the funera 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide the Hospital of within 24 hours a 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ello 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 Franklin Kell lare Drive 31. Date filed (Month, Day, State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** FEB OR: 27 PM Gerald D. Williams 2010 27 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner BALTIMORE AGNES HOSPITAL If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 192-28-5462 74 February 17,1936 Pennsylvania Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, if a Medical Evaniner must be notified at once. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes X☐ No Director Md. Balto. Nottingham 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 4616 Ballygar Road 21236 USA Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2X No ģ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Consultant Research- US Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marie Cole ဂ Donald E. Williams 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) <u>Jean M. Williams</u> Nottingham, Md. 21236
Date 20c. Location - City or Town, State Spouse 4616 Ballygar Road 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Bayview 3-2-2010 4 ☐ Donation 5 ☐ Other (Specify) Balto. Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home 9705 Belair Rd. Nottingham, Md. 21236 eur Ce. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) SCHEMIC CARDIOMYOPATHY UNKNOWN /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) that the death certificate be executed Due to (or as a consequence of): 68760 the attending physician Physician/Medical Box IF FEMALE for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No Ö 9 Unknown 9 Unknown 23e. Did tohacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 2 law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown FAILURE Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed or Attending Physician; The 2 No certificate 1 ☐ Yes 2 **N**0 Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident after death Director: filled in by the 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical

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State

To the I

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

CATON

BALTIMORE

MEKONEN, M.D.

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D64312

MD 21220

EYASU A MEKONEN, MID

29d. Date signed (Month, Day, Year)

FEB 27 2010

10-01600

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Jessica Wolski 1- For State Certificate of Death Rea. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death Physician/ Month Day February 23, 2010 0158 hrs Medical Examiner Jessica Wolski 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Baltimore** Union Memorial Hospital If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** oreign Hours Months Days Country) VA Director 250-49-4892 29 12-28-1980 1 M 2 X F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location ıny 10a State 10b. County Baltimore, MD 21215-0036

Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show Important: If item 27 is marked other than "natural", or items 23a or 28a-f show Important: If item 27 is marked other than "natural", or items 23a or 28a-f show Important: If item 27 is marked other than "natural", or items 23a or 28a-f show Important: If item 27 is marked other than "natural", or items 23a or 28a-f show Important International Registration Internation Internatio 1 X Yes 2 No Baltimore Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2728 St. Paul Street #2 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. 11. Marital Status Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 X Never Married 2 Married 2 X No Yes Asian 1 Yes 2 X No specify: Specify: 4 Divorced If Yes, Give Year à 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Sternographer Johns Hopkins 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) James K. Wolski Joanna S. Lee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James K. Wolski (Father) 4201 E. Craig St #3034 North Los Vegas, NV 89030 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 03-01-2010 Baltimore, MD Bavview Crematory 4 Donation 5 Other Specify 22. Name and Address of Facility Schimunek Funeral Home of BelAir 21. Signature of Funeral Service Licenses Inc 610 W. MacPhail Rd Bel Air, MD 21014 Approximate Interval 23a. Part I. Enter the disease, or complications that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and /Medical Death a Cardiac arrhythmia Immediate Cause (Final disease

Examiner

signed by the attending physician and be detached for use as the burial - transit Records, P.O. Box 68760,
The law requires that the death certificate be executed After this certificate has been uneral director, page 2 should Hospital or Attending Physician: 24 hours after death.

Division of Vital Records, P.O.

Examine Physician/Medical ģ Completed funeral director, Certification: Director: d in by the f within 24 hours a To the Funeral I

or condition resulting in death) Due to (or as a consequence of): b. Fraymentation of compact atrioventricular (AV) node Sequentially list conditions. Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): AMENDED PI X UNPENDED line a-b, 27, per ME, g902 4/20/10 TT IF FEMALE: 23d Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Ectopic pregnancy Month Dav Year Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown 9 [Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24a, Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed' 1 🗸 Yes 2 No ✓ Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical Other Nursing Home 5 Residence 6 Other Hospital: 1 Inpatient 2 🗸 ER/Outpatient 3 Inpatient 1 🗸 Yes 2 No 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 1 X Natural 1 Yes 2 No Pending Investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

30. Name and address of Jack Titus MD

ça (Che

State Registrar

Homicide 29a. Certifier

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) UU MAII

determined

and manner stated

erson who completed cause of death (Item 23a)

Deputy Chief Medical Examiner

32. Registrar's Signature ORIGINAL

OCME

29d. Date signed (Month, Day, Year)

February 23, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician February Gregory Marque Ranjith Wiratunga 27, 2010 9:15 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1510 Defoe Street Rockville Montgomery 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 🔀 M 2 🗆 F 73 Sri Lanka Director 224-98-6399 March 12, 1936 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits r 28a-f show 10a State 10b. County 10c. City. Town or Location 1 X Yes 2 No Director Maryland | Montgomery Rockville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code "natural", or items 23a or 1510 Defoe Street 20850 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Yes. Give \$ Specify: Asian 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5± Loan Officer World Bank 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Christopher Wiratunga ပ Amelia Wijesinghe 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Christine Wiratunga/Wife 1510 Defoe Street, Rockville, Maryland 20850 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Important: If it any Injury or c 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Montgomery Crematorium, Inc. 4 ☐ Donation 5 ☐ Other (Specify) March 6, 2010 Bethesda, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility R. bert A. Pumphrey Funeral Home/Bethesda—Chevy Chase, Inc. lauon M01530 7557 Wisconsin Avenue, Bethesda, Maryland 20850 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Metastatic Kidney Cancer Years resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Unitary g Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Exami attending physician and for use as the burial-tran Due to (or as a consequence of): The law requires that the death certificate be Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) □Yes 2□No detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Parkinson's Disease 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed? 1 □ Yes 2 🖾 No 1 ☐ Yes funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 A Residence 6 Other (Specify) 1 Tes 2 No Certification: To 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

Division of Vital Records, P.O. Box 68760 Hospital or Attending Physician: after death Director: filled in by within 2

> State Registrar

Medical

3 Suicide

29a. Certifier

4 Homicide

(Check only

29b. Signature and title of certifier

6 ☐ Could not be

Nancy Daw 31. Date filed (Month, Day Nancy Dawson, 3800 Reservoir Rd. NW, Washington, D.C. M.D. 2. Registrar's Signat

30. Name and address of berson who completed cause of death (Item 23a) (Type, Print)

and manner stated

DHMH 17 Rev 1/2001

🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number Mary and

Location (Street and Number or Rural Route Number, City or Town, State)

March 1, 2010

29d. Date signed (Month, Day, Year)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Linwood н. Wilson, Sr. Physician 602 M 2010 24 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ba. ale timore If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 6. Sex 7. Age (In yrs 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Social Security Number **Funeral** Year 1 🙀 M 2 🗆 F Months Virginia Director 212-30-5650 16,1933 Jan. Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show other traumatic event, the Medical Examinar must be notified at Baltimore Essex 1 ☐ Yes 2 ☐ No Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ō Pages 1 and 2 should be filed within 72 hours after death winnent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a 2 Russet Court 21221 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 □Yes 2 □ No

If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No Specify. þ Specify: 3 Widowed 4 Divorced Year or Dates: Korean White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Baltimore, Maryland 2121 Elementary/Secondary (0-12) College (1-4or 5+) Thompson Steel Co. Lineworker 10 Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Eliza Woodson George Wilson ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21221 Mrs. Juanita J. Wilson(Wife) 2 Russet Court Essex, Maryland 20b. Place of Disposition (Name of cognetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date permit. Pages 1 Department of H Important: If ite any Injury or ot 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Mem. Gdns. 3/1/2010 Middle River, MD # ☐ Other (Specify) 4 ☐ Donation neral Service Licens 22. Name and Address of Facility 21. Signature Duda-Ruck Fsneral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland Approximate Interval Between Onset and Death Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** resulting in death) /Medical Due to (of as a consequence of Examiner The Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed sician and burial-transit Due to (or as a consequence of) physician the buria Box 68760, Completed by Physician/Medical signed by the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) Ö 9 Unknown 9 Unknown σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 👿 No 3 Probably 4 Unknown been si should b 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an certificate has autopsy performed? Yes 2 X No 1 ☐ Yes Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2⊠No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D36663 02/24 2010 30. Name and address of person who completed cause of death (Item, 23a) (Type, Print) Drive 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Division of Vital Records, P.O. Box 68760,	he Hospital or Attending Bhysician. The law requires that the death continue to account
	he Hos

		State of Manyland / Dan		•	3
		1 _ State	artment of Health and M	lental Hygi	ene
		Registrar	ertificate of Death		g. No. U U U D / 1 9
Physici /Medic		1. Decedent's Name <i>(First, Middle, Last)</i> Laverne Vera W	illis	2. Date of Death Month FEDRUAR	Day Year
Examir	ner	4a. Facility Name (If not institution, give street and number). FRANKLIN SQUARL HOSPITAL	4b. City, Town, or Location of Death		4c. County of Death Balthmore
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 506–38–6035 1 M 2 F 76 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, June 27,	Year) 9. Birthplace (State or Foreign Country) 1933 Nebraska
sryland show	Ļ	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Evat. The must be notified at once.	Funeral Director	MD Baltimore 10e. Street and Number	Baltimore		1 ☐ Yes 2 ★No
23a ust b	20	7936 Landsdale Road	21224		United States
after dez	Fune	1 Never Married 2 Married 1 Yes 2 No	Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto	cify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
thours atural", call Ever	ted by	3 ☑ Widowed 4 ☐ Divorced If Yes, GIVE Year or Dates:	1 ☐ Yes 2 ☑ No Specify:		Specify: White Sb. Kind of Business/Industry
within 72 ene. than "na	Completed	(Specify only highest grade completed) (Give life. Elementary/Secondary (0-12) College (1-4or 5+) Unkn.	e kind of work done during most of worki DO NOT use retired)	ng	
filed Hygi ther		UTIKIT• 17. Father's Name (First, Middle, Last)	Sales 18. Mother's Name	(First Middle Ma	Retail
uld be Mental arked o	To Be	Henry Starkel		eth Schwi	•
d 2 sho th and I 7 is ma traums		l	ing Address (Street and Number or Rura 6 Landsdale Road)		City or Town, State, Zip Code) B. Maryland 21224
s 1 an if Heal item 2	1				Oc. Location - City or Town, State
. Pages tment of tant: If its jury or o			11 Mem. Gdns. 3/4/2	2010	Middle River, MD
permit. Depart Import any Inj once.	81 7		2. Name and Address of Facility Duda-Ruck Funeral I 1922 Wise Ave. Dur		
		23a Part 1. Enter the disease of complications that caused the death. Do not en shock, or heart failure, List only one cause on each line.	ter the mode of dying, such as cardiac of	r respiratory arres	t, Approximate Interval Between
Physician		Immediate Cause (Final disease or condition resulting in death)	ectension		Onset and Death
/Medical Examiner		Due to (or as a consequence of):			
rted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
icate be executed physician and s the burial-transit		that initiated events consequence of):			
fficate by physic is the bi	edical	d			
The law requires that the death certificate be eate has been signed by the attending physician page 2 should be detached for use as the buria	Physician/Med		☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery Month Day Year
w requires that the d s been signed by the should be detached	ρ	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did toba	cco use contribute to the cause of death?
aw requisite been	oletec			24a. Was an	24b. Were autopsy findings available
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 tompletely filled in by the funeral director, page 2.	Completed	OF Was asset of the day of the da		autopsy performe 1 Yes 2 D	prior to completion of cause of death?
s cert irecto	Be	25. Was case referred to medical examiner? \\ 1 □ Yes 2 \\ \text{No} \\ 1 \\ \text{No} \\ \text{Hospital: 1 \text{Minpatient 2 \sqrt{BR/Outpatient 2}} \\ \text{PB/Outpatient 2 \sqrt{BR/Outpatient 2}} \\ \text{No outpatient 3 \text{No outpatient 2}} \\ \text{No outpatient 3 \text{No outpatient 2}} \\ \text{No outpatient 3 \text{No outpatient 3}} \\ \text{No outpatient 3} \\	26. Place of Death		
ling Phy After this funeral d	ion: To	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury	f 28c. Injury at Work?	ne 5 Residence 8d. Describe how	ce 6 □Other (Specify) injury occurred
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be determined determined building, etc. (Specify)	M 1 ☐ Yes 2 ☐ No eet, factory, office 2	8f. Location (Stree City or Town, S	et and Number or Rural Route Number,
spital or nours af neral Di		29a. Certifler 12 Certifying Physician: To the best of my knowledge, deat	h occurred at the time, date and place, a	nd due to the cau	sea(e) and manner as stated
the Ho thin 24 I the Fu mpletely	Medical	one) Amedical Examiner: On the basis of examination and/or in and manner stated.	vestigation, in my opinion, death occurre	d at the time, date	e and place, and due to the cause(s)
7 wii	-	29b. Signature and title of certifier August August M.D. M.D.	29c. License number		Date signed (Month, Day, Year)
		30. Name and address of person who completed cause of death (item 23a) (Type,	Print)	\n.io -	2-26-2010 Balto. MD 21237
Stat	_	31. Date filed (Month Day 2010) 32. Registrar's Agnature and	AUKIN ZONHE I	nuve	DIIIO. 1111 2123' /
Registra	r	min - Lore			

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death Physician/ Month Day Year 2010 2:30 PM February Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death If Unde If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day 1 □ M 2 💢 F **Director** Yrs. iral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Xyes 2 No 10e. Street and Number 10g. Citizen of What Country? Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) life, DO NOT use retired) Elementary/Seconday (0-12) Be Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Informant's Name/Relationship (Type, P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (mother) Method of Disposition

Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory, MD Balto of Juneral Service Licensee Signat 22. Name and Address of Facility 23a. Part 1 Enter he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Ons t and Death cervical come Immediate Cause (Final Ph sician/ disease or condition resulting in death) 6 MONTH Medical Examiner Hyro Kalemia >2 weeks Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician; The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 F FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months? 1 ☐ Yes 2 No Day Month Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 No 2 □ No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy death? To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 21 10 Other: 1 Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours atter death.

To the Funeral Director: After this 27. Manner of Death Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural Pending 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Lecrifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) AT 2438 94 ein Kulkam 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, MAR 0 MEMORIAL HOSP ITAL UNION Registrar's Signatu State 5 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JOHN WALLACE February 2010 07:35 p^M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Fairfield Nursing Home Crownsville Anne Arundel Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
Jun 27 1930 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Birthpis Country) DC 1 X M 2 A Hours Director 579-34-3317 79 Usual Residence of Decedent ms 23a or 28a-f show must be notified at . Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. It means the marked other than "natural", or items 23a or 28a-f sho itant! If then 27 is marked other than "natural", or items 23a or 28a-f sho iury or other traumatic event, the Medical Examiner must be notified at jury or other traumatic event, the Medical Examiner must be notified at 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Director MD Prince Georges Lanham 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 6908 Forbes Blvd. 20706 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian If Yes, specify Cuban, Mexican, Puerto Rican, etc. à 1 Never Married 2 X Married Black, White, etc. Maryland 21215-0036 1 Yes 2 No Specify: Completed 3 Widowed 4 Divorced Specify: Year or Dates Black 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Bus Driver Metro 4vrs Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ John L. Wallace, Sr. Annie Pearl Dixon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peggy Wallace - Wife 6908 Forbes Blvd. Lanham, Md. 20706 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Veterans Cemetery 3-10-2010 Cheltenham, MD 21. Signature of Funeral Service Licensee Marshall's Funeral Home of Maryland 4308 Suitlnad Rd. Suitland, MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) **Examiner** Sequentially list conditions Examine cause. Enter Underlying Cause (Disease or linjury that initiated events the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Pregnant at time of death Day Year ate has been signed by the page 2 should be detached 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed' 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 Mo Hospital Other: ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After Natural 5 Pending work? 2 🔲 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, usual occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and tit

Registrar
DHMH 17 Rev 7/2009

State

32. Registrar's Signature

Brain Highway SW

10-0163	9
Thedius	Wallace

DHMH 17 Rev 1/2001

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		1- For State Registrar	Cer	rtificate of De	ath	Re	eg. No.	
Physici		Decedent's Name (First, Middle,La				Date of Death Month	h	3. Time of Death
`⁻dical Exami	ner	Thedius	Wallace			February 2	Day Year 24, 2010	0015 hrs
		4a. Facility Name (if not institution, g	ive street and number)		ty, Town, or Location of De	ath	4c. County of Death	1
		Sinai Hospital		Ba	altimore			
Funeral		Social Security Number 6. 3	Sex 7. Age (In yrs. I		Under 1 Year If Under 24		th(MM/DD/YYYY) 9. Birt Foreig	
Director		738-48-6830 1	M 2 F	79 Yrs. MC	onths Days Hours N	vin. 2-7.	-193/ co	untry) // C
_		Usual Residence of Decedent						
* any		10a. State 10b. County		, Town or Location				10d. Inside City Limits
Maryland 28a-f show 1 at once.	5	mi) 13a1+	imore Pi	Kesville	2			1 Yes 2 No
Maryl 28a-i d at c	rector	10e. Street and Number	1	10f.	Zip Code	10	ng. Citizen of What Cour	ntry?
ith the M 23a or 2 notified	اۃ	8005 McDo	nouch Koai	d	21208		USA	
h with	Funeral	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?		cedent of Hispanic Origin? (becify Cuban, Mexican, Pue		- 14. Race - Ameri White, etc.	can Indian, Black,
r deatl or ite must	뒤	1 Never Married 2 Marfie	1 Yes 2 No		_/	ato moun, e.e.,	7	. 1/
ours after atural", c	J.		ed If Yes, Give Year or Dates:		2 No specify:		Specify: 15	ack
hour:	eted	15. Decedent's Education (Specify			sual Dccupation (Give kind of working life, DO NOT use it		16b. Kind of Business/I	ndustry
5-0036 led within 72 h Hygiene. tother than "n the Medical E	plet	Elementary/Secondary (0-12)	College (1-4 or 5+)	01.1	1000 D	11.1/2	r-da-	1
5-0036 iled within 7 Hygiene. d other than	dmo	17. Father's Name (First, Middle, Las	<i>~</i>	(nilo	1 Cart F	me (First, Middle, M	1-05/Er	Care
15-	Be	17. Patrier's Name (First, Windle, 200	7)		Po H	/ Condition	alden oumand,	
2121 Mental Filmarked Marked Control	To B	19a Informant's Name/Relationship	(Type, Print)	19b. Mailing Addr	ress (Street and Number	or Rural Route Num	her. City or Town, State	7in Code)
C S S S S	-1	DITI	son Daushta	- 81115	une Danquel	RN Pik	1 . 11	21208
P P F E E		20a. Method of Disposition	20b. I	Place of Disposition (Date	20c. Location - City or	
5 % ≥ ± ₹		1 Burial 2 Cremation 3	Removal from State 2	crematory or other pla	11/1	1-2010	Varache	110
	1	4 Donation 5 Other Specif 21 Signature of Funeral Service Lice			and Address of Fallit	,62010	vancero	ro. 14 (
Ball permit Depart Impor		21. Signature di Fulleral Servica Licc	Asee	003	Colonia Audiess of Familia	USINCIE	ireene runei	ral Services
Physician		23a. Part I. Ent r the disease, o com	polications that caused the death	. Do not enter the mo	de of dying, such a cardia	r respiratory arre		Approximate Interval
/Medical		failure. List only one cause on e	each line.					Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence or		ring Colonoscopy			
).	· · · · · · · · · · · · · · · · · · ·				
	Ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence of	f):				
	miner	cause. Enter Underlying Cause (Disease or injury that initiated).					
	Exa	events resulting in death) Last	Due to (or as a consequence of	1):				
executed in and in transi		UNPENDED	AMENDED					
4 .5 .6	/Medical]					Too ! Data of deliver	<u> </u>
		IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of pregi	nancy 2 Fetal dea	ath 3 Ectopic preg	onancy	23d. Date of delivery Month	v Day Year
Box 68's death certiff the attending and for use as the second of the se	sician	past 12 months?	4 Pregnant at time of de			g, te,		,,
BO)	Phys	1 Yes 2 V No 9 Unknow	9 Unknown					
P.O. s that the gned by the detache		Part II. Other significant conditions	-				bacco use contribute to	
s, P.C irres that signed d be dete	od by	Hypertensive Atheroscle	erotic Cardiovascular Dise	ease; Gallbladde	er tumor	_ 1 Yes	2 No 3 Prob	oably 4 🗸 Unknown
Records, The law require freate has been si	Completed					24a. Was a		topsy findings available completion of cause of
eco ne law te has ige 2 si	퇴		· <u></u>			perform	med? death?	·
tal Recian: The		25. Was case referred to medical			26.Place of Death (Chec			2 110
Division of Vital Records, P.O. Box 68 the Hospital or Attending Physician: The law requires that the death certifier the Funcial price or After this certificate has been signed by the attending in pletely filled in by the funeral director.	Be	examiner?	Hospital: 1 🗸 Inpatient 2	ER/Outpatient 3	Othor	rsing Home 5 F	Residence 6 Other	
of V ing Phy: After thi	٢.	1 Yes 2 No 27. Manner of Death	28a Date of Injury	28b. Time of Injury	28c. Injury at Work?	28d. Describe h	ow injury occurred	
nding th. Af	힐	1 Natural 5 Pending	FOUND: Day, Year)	FOUND:	1 Yes 2 ✓ No	Rectum perfe	orated during colo	noscopy
Division tal or Attendii rs after death. al Director: A	Certification:	2 🗸 Accident Investiga	28e Place of Injury - At he	0000 hrs ome, farm, street, fact		28f. Location (S	treet and Number or Ru	ral Route Number, City
Divi	Ħ.	3 Suicide 6 Could no determine	it be	, , , , , , , , , , , , , , , , , , , ,		or Town, St , Baltimore, MI		-
Hospit 124 hour F Funer etely fill		29a. Certifier	cian: To the best of my knowledge	ne death occurred at	the time, date and place, a	1		ad
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical	(one only	er: On the basis of examination a	-				
To Witl	ĕ l	29b. Signature and title of certifier	and manner stated.		29c. License number		29d. Date signed (Mor	nth, Day, Year)
		1.11/			O.C.M.E.		February 24, 201	0
η	- 1	30. Name and address of person who	completed source shorth (Items					
1		Russell Alexander MD.	Assistant Medical Exam	·	n Street, Baltimore,	MD 21201		
St	ate		32. Registrar's Signatu					
Regist		MAD IL W AAJ		han dad	1			

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ March Medical Facility Name (if not institution, 4c. County of Death Examiner Medica If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** (Month, Day, Ye May 31. Country) Maryland 1 🕅 M 2 🗆 F 70 Yrs Director 214-34-3429 Usual Residence of Decedent 23a or 28a-f show ist be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 Yes 2 No MD Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral must 8538 Drumwood Road 21286 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Page 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any inluy or other traumatic event, the Medical Examiner. 14. Race - American Indian. Black, White, etc 1 Never Married 2 X Married 1 X Yes 2 ☐ No If Yes, Give Completed by 1 ☐ Yes 2 X No Specify: white 3 Widowed 4 Divorced **'**57**-**61 Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) salesperson supply company Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 John Roop Woodward Marie Louise LaPorte 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $8539\ Drumwood\ Road\ Towson$, MD 2128619a. Informant's Name/Relationship (Type, Print) Lois Woodward/spouse 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town. State 1

Burial 2

Cremation 3

Removal from State cemetery, crematory or other place) 4 X Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
State Anatomy Board
Baltimore, MD 2120 Signature of Funeral Service Ronal d 655 W. Baltimore Street Enter the diserve, or emplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate vuse (Final disease or condition resulting in death) Physician/ Metastatic mostal Medical Due to (or as a consequence of Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Cause (Disease or iinjury the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): as been signed by the attending physician 2 should be detached for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Pregnant at time of death Month Day Year Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy pade death? 1 ☐ Yes 2 ☐ No Yes funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 2 No ျှ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

State Registrar DHMH 17 Rev 7/2009 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

21215-0036

Box 68760

P.O.

Records,

Division of Vital

ALTIMORE

29c. License numbe

VA MEDICAL

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month Year 10:05A M Douglas Warner, Jr. March 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Cockeysville Broadnead 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 X M 2 🗆 F Hours (Month, Day, Yo 84 Director 213-32-0521 Maryland Sept. Usual Residence of Decedent 10a. State 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director Baltimore Cockeysville MD 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
United States Funeral 13801 York Road, Apt M7 21030 12. Was Decedent Ever in U.S Armed Forces? 1

X Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian Black, White, etc 1 Never Married 2 Married Completed by White 1 ☐ Yes 2 X No Specify: "natural", 3 Widowed 4 Divorced Year or Dates Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Essex Community Elementary/Seconday (0-12) College (1-4 or 5+) Professor of Physics College Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Douglas Warner, Sr. Margaret Kelly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13801 York Road, Apt M7, Cookeysville, Maryland 21030 Nancy Warmer - Scouse Baltimore, 20a Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Evans Funeral Chapel &
Cremation Services-BelAir 1 Durial 2 X Cremation 3 Removal from State Forest Hill, Maryland 4 Donation 5 Other (Specify) permit. 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Services — Monkton
16924 York Road, Monkton, Maryland 21111 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) cerstorascular Medical Due to (or as a consequence of Examiner Sequentially list conditions cause Enter Underlying Cause (Disease or iinjury attending physician and that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 WARNER, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death Day Year 2 🗌 No 9 Unknown the 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 1 Yes page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No. 24a. Was an autopsy performed has within 24 hours after death.

To the Funeral Director. After this certificate homeleted filled in by the funeral director, page Ves Be Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 140 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 Natural iniurv 5 Pending 2 🗌 No Investigation Accident Suicide 6 🗆 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 \square Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifit 29d. Date signed (Month. Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cochagenlle mo 21030 YRUC 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

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DOUGL4

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 7:45 P.M elornor Virginia Elsie Wood Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Washington Medical Ctr Glen Burnie Arundel Anne 8. Date of Birth (Month, Day, June 22 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** Days Hours Min. Year) 1 M 2 X F Months Director 190-14-7540 86 1923 Pennsylvania June Usual Residence of Decedent or 28a-f show 10b. County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10d. Inside City Limits Director 1 Yes 2 TNo MD Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21061 102 N. Crain Hgwy USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14 Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 Married þ white Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates. 144-45 3 X Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 10 0 switchboard operator communications Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ဂ္ George Robert Lawrence Margaret Elizabeth Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 301 Hospital Drive Glen Burnie, MD 21061 Baltimore Washington Medical Ctr 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1

Burial 2

Cremation 3

Removal from State 4 X Donation 5 Other (Specify) Signa ure uneral Service Konald State and Address of Source Street Baltimore. MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the hurial-transit that initiated events Due to or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death Other (specify) 1 Yes 2 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Tyes 2 X No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performe

P.O. Box 68760 Division of Vital Records,

1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 🗌 Yes 1 N npatient 2 ER/Outpatient 3 DOA 27. Manner of De th 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural (Month, Day, Year) 5 Pending 2 🗌 No 1 Yes Investigation
6 Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier

Be

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Certificate:

Medical

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, unity opinion, detail occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

MAR U 5 2010

Brum

30. Name an s of person who completed cause of death (Item 23a) (Type, Print)

Dav. Year) 32. Registrar's

State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 27, 2010 **Physician** 11:20 AM Naomi Caroline Warner /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Rossville Manor Care If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign 6 Sex 7 Age (In vrs last birthday) 8. Date of Birth (Month, Day, Funeral Months Days Hours New York 1 M 2 F 91 Director 122-09-0134 Jan.7,1919 Usual Residence of Decedent 10d Inside City Limits 10a, State 10b. County 10c. City, Town or Location 28a-f show ortant: If item 27 Is marked other than "natural", or items 23a or 28a-f shov Injury or other traumatic event, Ite Machal Examinat mast be positived at Nottingham Baltimore 1 ☐ Yes 2 No Director MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21236 USA 8837 Terrell Road by Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Ye ar or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married white 1 ☐ Yes 2 ☐No Specify: Specify: 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, In Monee. At Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lucie Hall Albert Loucks ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8837 Terrell Road-Nottingham, Maryland 21236 Thomas Warner-son 20b. Place of Disposition (Name of cemetery, crematory or other place)
Evans Funeral
Chapel & Cremation Belair

Mak. 4,2000 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Forest Hill, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Evans Funeral Chapel and Cremation Services 8800 Harford Road-Parkville, Maryland 21234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Demente. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Degeneative physician and s the burial-trans Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Live birth 2 Fetal death 3 Ectopic pregnancy Month Day 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) I∐Yes 2⊉No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an his certificate has b I director, page 2 sl autopsy performed? Yes 2.21No 2 □No 1 ☐ Yes 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural nours after death.

neral Director: A
y filled in by the fu 1 ☐Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) within 2. and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD D 31464 3/1/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9 821 N. EYTAW ST Shite 308 Baltimore MD 21201 . HASHMI MD 32. R gistrar's Signature State

Registrar

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 06/ Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day, 49am 5 2010 Mary Ada Wheeler rebruar 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Medica Mata Charles Ivista La Contes 8. Date of Birth (Month, Day, Y 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) . 192<u>2</u> 1 □ M 2 😾 F Months Days Hours Min. Sept 235 28 4833 87 Ohio Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State MD P.G. Brandywine 1 ☐ Yes 2XXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7000 Burch Hill Road 20613 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 □Yes 2□No Specify. Specify: X Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Housekeeper Health Care 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lylburn Lee Tyler Alice Gaskins 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas Wheeler (Son) 7000 Burch Hill Road, Brandywine , MD 20613 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 XBuriai 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln Cemetery 3/2/2010 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d 21. Signature of Funeral Service Licensee IN01222 | Alexandria Ferry Road, Clinton, MD 23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final NEARERENT disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 - Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 9 Unknown 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 1 ☐ Yes 2 🙇 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗆 No 1 ☐ Yes 2 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2XNo 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mannet of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending

Physician /Medical Examiner law requires that the death certificate be executed sician and burial-trans the. attending p

Physician

/Medical

Examiner

Funeral

Director

28a-f show

or items 23a or

"natural"

marked other

27

h and Mental h

Health

permit. Pages 1 and Department of Health Important; If item 27 any injury or other tr

Baltimore,

Box 68760,

P.O.

Vital Records,

ot

Division

Director

Funeral

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Completed

traumatic event, the Medical Examiner must be notified at

 M_{GN} M_R - 45084 Maryland 21215-0036

Exami Physician/Medical 2 Completed Be Medical Certification: To

cate has been signed by the page 2 should be detached Physician; The certificate Hospital or Attending death. by the filled in I

24 hours after deat Funeral Director: completely within 2

: After this certifica e funeral director, p

State Registrar

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only

investigation

☐ Could not be

determined

29b. Signature and title of certifier

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

person who completed cause of death (Item 23a) (Type, Print 0

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed After this certificate has been

:≝	- 1	1 Burial 2 Cremation	3 Removal from State	A	lace)	2/5/100	Dell	11
9		4 Donation 5 Other Speci		letro Cr	emathry!	3/5/2010	Balto	IVIA.
injury or othe		21 Signature of Funeral Service Lice	ensee	22 Name	and Address of Facility	- 4 14	Ω Λ	
: .≘′	-88	Jaroph o	X . YUM	277	ph Lituss	Fyneral	me Pitt.	21216
an		23a Part I. Enter he disease, or con	nplications that caused the dea	ath. Do not enter the mo	ode of dying, such as card	iac or respiratory arre	st, shock, or heart	Approximate Interval
cal		failure. List thly one cause on		alauatia Caudiaya	acular Diaccas			Between Onset and Death
ner		Immediate Cause (Final disease or condition resulting in death)	a. Hypertensive Atheros Due to (or as a consequence		scurar Disease			
				e 01):				
	<u>_</u>	Sequentially list conditions, if any leading to immediate	 Due to for es a consequence 	2.21.				
ш	<u>ا چ</u>	cause. Enter Underlying Cause	C.	e-U1):				
	Examine	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence	e of):				
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<u>+</u>	dical	UNPENDED	AMENDED					
Puri	യ⊩							-
the late		IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of pr	,			23d. Date of delivery	
se a	Cal	past 12 months?	1 Live birth 4 Pregnant at time of	2 Fetal de		egnancy	Month D	ay Year
for u	· Š	1 Yes 2 No 9 Unknow		death 5 Other (Specify)			
ched	흾	Part II. Other significant conditions		ot resulting in the under	ving cause given in Part I	23e Did toh	acco use contribute to t	he cause of death?
deta	ক্র	Chronic Alcoholism; Ast		tresulting in the dilucin	ying cadoo given in rait i.	1 Yes		ably 4 V Unknown
ld be	ᄝᅵ	Chronic Alcoholishi, Ast	IIIIa					
shou	Complete					24a. Was ai autops		opsy findings available ompletion of cause of
ge 2	ĔΙ	·				perform 1 ✓ Yes 2	ned? death?	s 2 No
ır, pa		25. Was case referred to medical			26.Place of Death (Ch		No 1 ✓ Ye	S 2 NO
recto	ŏ	examiner?	Hospital: 1 Innatient 2	ER/Outpatient 3	Othor			
ral d	유	1 Yes 2 No	28a. Date of Injury	28b. Time of Injury	28c. Injury at Work?		tesidence 6 🗸 Other:	Scene
fune	ä۱	1 V Natural	(Month, Day,Year)	260. Time of injury			ow injury occurred	
the	<u></u>	2 Accident Pending			1 Yes 2 No			
i i	읡	3 Suicide 6 Could no	28e Place of Injury - At	t home, farm, street, fac	tory, office building, etc.		reet and Number or Run	al Route Number, City
lled	Certification:	4 Homicide determin	ned (Specify)			or Town, Sta	ite)	
tely f		29a. Certifier 1 Certifying Physi	ician: To the best of my knowle	edge, death occurred a	t the time, date and place.	and due to the cause	(s) and manner as state	d.
completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Medical		er:On the basis of examination					
S	왉	29b. Signature and title of certifier	and manner stated.		29c. License number		29d. Date signed (Mon	th, Day, Year)
		/ // at /	0. 41()		O.C.M.E.	1	March 2, 2010	
	- [(/ / white	em		J.O.N.L.		11010112, 2010	

06728

3. Time of Death

1143 hrs

10d. Inside City Limits

1 XYes 2 No

State Registra

OCME

Laron Locke MD

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

111 Penn Street, Baltimore, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2010 Physician/ Pailin Yau 7:20 PM M March Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Manor Care Potomac Potomac Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** (Month, Day, Year, June 6 Country) Taiwan Months Days Hours 1 □ M 2 👿 F Director 220-51-6585 59 Usual Residence of Decedent 28a-f show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2X No Bethesda Montgomery ь 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 7315 Spring Lake Drive #D1 20817 USA items within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. "natural", or 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: asian Specify: Completed 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than College (1-4 or 5+) 5+ Elementary/Seconday (0-12) nonprofit organization 12 office manager other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 be Grace Lee Kit Sum Ho Yau 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $14102\ Tatani\ Drive\ Boyds,\ MD\ 20841$ permit. Page 1 and 2 sh Department of Health a Important: If item 27 is Paul Yau/brother Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date injury or 1
Burial 2 Cremation 3 Removal from State 4 X Donation 5 Other (Specify) Signature of Kneral Service Li Wade, State Anatomy Board 655 W. Baltimore Street rector Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician disease or condition metastatic breast cancer Medical resulting in death) Due to (or as a consequence of): Examiner meningeal carcinomatosis Sequentially list conditions, Examine Due to (or se a consequence of) if any, leading to immediate cause. Enter Underlying Physician: The law requires that the death certificate be executed burial-trans Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last physician s the burial Physician/Medical Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No for Month Day Year Pregnant at time of death been signed by the should be detached 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of 24a. Was an nas autopsy page death? 1 Yes 2 No Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital 1 Tes 2 XNo <u>۾</u>| 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred After To the Hospital or Attending injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: At completed filled in by the fu Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number,

State Registrar

Medical

29a. Certifier

only one 29b. Signa

the and title of

determined

Wang

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ilva 32. Registrar's Sig

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

R175265

29d. Date signed (Month, Day, Year) 3/1/2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Dep		Mental Hygie	ene
				ertificate of Death	Reg	1. No.2010 06730
	Physici	an	1. Decedent's Name (First, Middle, Last)		Date of Death Month	3. Time of Death
-	/Medi		Florence Margaret Zachman		March	1 2010 4:00 A M
,	Examir	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Dea	th	4c. County of Death
			Chesapeake Hospice - Mandrin House 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	Harwood If Under 1 Year If Under 24 Hrs	Dobo of Dinth	Anne Arundel
	Funeral Director		1 □ M 2 🕅 F	Months Days Hours Min	. (Month, Day, Y	9. Birthplace (State or Foreign Country)
			217-40-6428 66 Tis. Usual Residence of Decedent		04/08/19	Maryland
	how		10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits
	e Ma	cto	MD Anne Arundel Harwood			1 ☐ Yes 2 🛣 No
	or 28	Director	10e. Street and Number	10f. Zip Code	10g	g. Citizen of What Country?
	ath w	ral	3675 Solomons Island Road	20776		U.S.A.
	er de	Funeral	Armed Forces?	. Was Decedent of Hispanic Origin? (\$ If Yes, specify Cuban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc.
36	72 hours after death with the Maryland 'natural', or items 23a or 28a-f show diest Evanities and the profitted at	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give 3 ☐ Widowed 4 ☒ Divorced Year or Dates:	1 ☐Yes 2X No Specify:		Specify: White
21215-0036	2 hou	pa	15. Decedent's Education 16a. Dece	edent's Usual Occupation	16	ib. Kind of Business/Industry
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7	d with	Son	12	Assembler		Pellet Stoves
pu	e file tal Hy d oth	Be (17. Father's Name (First, Middle, Last)		me (First, Middle, Ma	iden Surname)
yla	Meni Meni arked	10	Vernon Louis Zachman	Floren	ce Witzl	ler
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Experiment must be rediffied at once.			ing Address (Street and Number or R		
e)	l and Health			2 Alabama Avenue,		
altimore,	Pages 'nent of hant of hant if ite		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition cemetery, creation 3 □ Removal from State	matory or other place)		c. Location - City or Town, State
Ħ.	it. Pa irtmel irtant njury	l k				Manover, Maryland
Ba	permi Depar Impor any ir			2. Name and Address of Facility A		
			23a. Part 1. Enter the disease, or complications that caused the death. Do not er			Hanover, MD 21076
	Obvoicion	5. 1	shock, or heart failure. List only one cause on each line. Immediate Cause (Final	nor the mode of dying, oddr do sardia	o or respiratory arrest	Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death) a. Due to (or as a consequence of):			
	Examiner					
	D .±	ner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
	ecute and trans	Examiner	Cause (Disease or injury that initiated events c.			
60,	death certificate be executed e attending physician and d for use as the burial-transit		Due to (or as a consequence of):			
58760,	icate phys	edical	d			
Box	eath certific attending p for use as		IF FEMALE: 23b. Was decodent propert 23c. If yes, outcome of pregnancy			22d Data of delivers
ŏ	death	Physician/M	in the past 12 months? 1 Live birth 2 Fetal death 3	☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery Month Day Year
<u>Р</u> О	t the c	hysi	9 Unknown	(-),,		
T.	The law requires that the do are has been signed by the page 2 should be detached	by P	Part II. Other significant conditions contributing to death but not resulting in the u	inderlying cause given in Part I.	23e. Did tobac	cco use contribute to the cause of death?
Records,	en siç	ed			1) Yes	2 ☐ No 3 ☐ Probably 4 ☐ Unknown
ည္ထ	elaw re hasbe je 2 sho	plet			24a. Was an	24b. Were autopsy findings available
		Completed			autopsy performe 1 ☐ Yes 2 🗓	prior to completion of cause of death? No 1 □ Yes 2 ☑ No
VItal V	nding Physician: Th. th. : After this certificate : funeral director, pag	BeC	25. Was case referred to medical examiner?	26. Place of Dea	ath (Check only one)	MODIFIES 2500
7	hysion this o	၉	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie	nt 3 ☐ DOA Other: 4 ☐ Nursing H	lome 5 ☐ Residenc	ce 6 Other (Specify)
ב ב	ing P	ü	27. Manner of Teath 1 X Natural 5 □ Pending 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Injury	Work?	28d. Describe how	injury accurred
DIVISION OF	ttend death tor: , the f	cati	2 Accident investigation	M 1 □Yes 2 □No		
≥ ່	or Ai after of Direct in by	Certification:	4 Homicide determined 28e. Place of Injury - At home, farm, ste building, etc. (Specify)	reet, factory, office	28f. Location (Stree City or Town, S	et and Number or Rural Route Number, State)
_	spital ours neral filled		29a. Certifier Certifying Physician: To the best of my knowledge, deal	th occurred at the time, date and place	e and due to the caus	se/s) and manner as stated
:	to the hospital or Attending Physician: within 24 hours after death. To the Luneral Director: After this certifica completely filled in by the funeral director, to	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.	nvestigation, in my opinion, death occi	urred at the time, date	and place, and due to the cause(s)
:	vithii To th	ž	29b. Signature and title of certifier	29c. License number		. Date signed (Month, Day, Year)
			Jeanine werny, mo	052830	m	Over 1,2010
		ļ	30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)	. 11 -	1 . 440
			Planine Werner MD, 900	Bestgate Rue	200 #300	aven 1,2010 Annopsiis, MO 21421
	Stat Registra	_	31. Date filed Month, Car Vear 32. Registrar's Signature	les .		

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Barnett R. Ampolsk February 8, 2010 6:55 A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Potomac Valley Nursing Home Rockville Montgomery If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Year) Days Hours 1 ★ M 2 □ F Director 111-22-1301 1922 New York 11 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylä Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examin or must be neutified at once. 28a-f show 1 ☐Yes 2 ☐ No Directo Rockville Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 1235 Potomac Valley Road #C125-A 20850 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1942 -Baltimore, Maryland 21215-0036 1 ☐Yes 2√2 No Specify. Specify: White ò 3 ₩ Widowed 4 Divorced 1945 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) <u>Magazines</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Abraham Ampolsk Esther Taplinger ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 10322 Strathmore Hall Street Apt 411 N. Bethesda Alan Ampolsk/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【 Cremation 3 【 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) National Crematory 2/17/2010 Falls Church, Virginia 21. Signature of Funeral Service Licensee Melissa Greenhut 22. Name and Address Dathansky-Goldberg Memorial Chapel M01597 1170 Rockville Pike Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physiclan: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of): Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy 23d, Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 1 Live birth 2 Fetal death 3 Ectopic pregnancy 5 ☐ Other (specify) P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home Certification: To 5 ☐ Residence 6 ☐ Other (Specify) Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred Vatural 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Research BLVD Su rcette 2 nahi

DHMH 17 Rev 1/2001

State Registrar 31. Date filed

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, 0 1 0 05732
State of Maryland / Department of Hoolib and Maryland / Department of Hoolib and Maryland Lawrence Edward Andrews 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death 3. Time of Death Month Day February 18, 2010 0927 hrs Medical Examiner Lawrence Edward Andrews 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 1701 Whitehead Road Gwynn Oak **Baltimore County** 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Days Months Hours Director 07/22/1952 Country) MD 217 64 6467 1X M 2 F 57 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County s 23a or 28a-f show e notified at once. 1 Yes 2 XNo MD Windsor Mill Baltimore Director 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? 7126 Rolling Bend Road 21244 United States Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married 2 X No Yes Specify: White 4 X Divorced If Yes, Give Year Yes 2 No specify: ⋧ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Completed Elementary/Secondary (0-12) College (1-4 or 5+) Construction Carpenter 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lewis M. Andrews Clara B. La Mar æ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) မ 12735 Triadelphia Rd. Ellicott City, MD 21042 Wesley R. Daub/Personal Repr. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery Date 20c. Location - City or Town, State crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Baltimo
permit. Page
Department of
Important: Ardent Crematory 2-23-2010 Hanover, MD Donation 5 Other Specify 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. M01044 21. Signature of Funeral Service Licenses 4112 Old Columbia Pike Ellicott City, Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line /Medical Death a. Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and sician/Medical UNPENDED attending physician a AMENDED Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Live birth Fetal death 3 Ectopic pregnancy Month Day Year 2 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown g Unknown this certificate has been signed by the a director, page 2 should be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 Yes 2 No 3 ✔ Probably 4 Unknown Completed 24b. Were autopsy findings available 24a Was an autopsy prior to completion of cause of death? performed? Yes 2 No 1 🗸 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death. 25. Was case referred to medical 26. Place of Death (Check only one) æ Other 5 Residence 6 🗸 Other Scene ER/Outpatient 3 DOA Inpatient 2 1 Yes 28a. Date of Injury (Month, Day, Year) After 1 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Certification 1 V Natural 1 Yes 2 No Pending the Director: Investigation 2 ___ Accident filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) (Specify) To the Funeral Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) February 19, 2010 O.C.M.E. Shall ML 30 Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day Year) 32 Registrar's Signature State

DHMH 17 Rev 1/2001 **OCME 2006**

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February 14, 2010 HELEN M. ARGO 12:40 Am 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Kline Hospice House Mt. Airy Frederick 8. Date of Birth (Month, Day, Oct. 6, 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Months Days Hours Min. 1923 Mary Land 1 □ M 2√□ F 219-12-4621 86 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2√☐ No Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5955 Quinn Orchard Road 21704 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: White 3 XWidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Secretary Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William D. Miller Margaret E. Haller 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra A. Freeman / Daughter 7102 Ridge Road, Frederick, Maryland 21702 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Smithsburg Crematory 2/16/2010 Smithsburg, Maryland 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Lin ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET STREET, FREDERICK, MD 21701 23a. Part 1. Enter the disease, or complications that caused the heath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final rebable Chelangir (aveinama disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3

Ectopic pregnancy in the past 12 month Month Day Year 5 ☐ Other (specify) □Yes 2 No 9 Unknown 9 🗆 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed Yes 2 2 No 1 □ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one)

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

by Funeral

Completed

Be

ပ

Funeral

Director

show

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It a Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

ending physician and use as the burial-tran attending p the signed by t d be detach peen has this certificate After death. Director: d in by the

The law requires that the death certificate be executed

or Attending Physician:

Hospital

Box 68760,

P.O. |

of Vital Records,

Division

Examiner Physician/Medical þ Completed Be မ Medical Certification: To the Hospital within 24 hours a To the Funeral C

1 ☐ Yes 2 ☐ №

27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide

29a. Certifier (Check only one)

29b. Signature and title of certifier

Day,

5 Pending investigation 6 Could not be

28a. Date of Injury (Month, Day, Year)

Hospital:

MD

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28b. Time of 28c. Injury at Work?

1 ☐ Yes 2 ☐ No

Other: 4 \sum Nursing Home

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

20

31. Date filed (Month, State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

1 homas Registrar's Signature

Tohnson DV

DGOUIT

5 ☐ Residence 6 ☐ Other (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

21702

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Sally J. Anderson February 2:45 P. 10,2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Clinton Nursing & Rehab. Clinton Center Prince George's 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 F Months Davs Hours Min 73 Director 578-50-8267 05/16/1936 Fauquier Co., Va. Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show if than "natural", or items 23a or 28a-f show 1√Yes 2 No Director P.G. Md. Clinton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9211 Stuart Lane 20735 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ XNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 African-1 ☐ Yes 2 🔀 No Specify þ 3 Widowed 4 □ Divorced American Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene, Important: If item 27 is marked other than "any Injury or other traumatic event, the We ponee. Elementary/Secondary (0-12) College (1-4or 5+) 12th Cashier Retail Sales 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Gertrude Grayson Lee Champ ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Reginald Anderson/Son 2401 30th St., N.E., Washington, D.C. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Quantico Nat'l. Cem. 02/18/10 Triangle, Va. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
H.S. Washington & Sons Co., Inc.
4925 Burroughs Ave., N.E., Washington, D.C. 20019 21. Signature of Funeral Service Licensee avz. 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Dementia 2004 /Medical Due to (or as a consequence of): Examiner 2004 Congestive Heart Failure with Pacer Sequentially list conditions Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 2004 <u>Cerebrovascular</u> Accident and burial-tra Box 68760. attending physician certificate be Physician/Medical <u>Insulin Dependent Diabetes Mellitus</u> 2004 the as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 No Month Day Year 5 ☐ Other (specify) P.O. the 9 Unknown à signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Ď. Sacral Wound with Infection 1 Tyes 2 No 3 Probably 4 Unknown page 2 should Completed Chronic Obstructive Pulmonary Disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate performed 2 **N**0 1 ∐ Yes 1 ☐Yes 2 ☐No Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After 1 Certification: 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 5 ☐ Pending investigation 1 Natural death. 1 □Yes 2 □ No 124 hours after death. e Funeral Director: / 2 Accident 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) William FARTICENCAND manner stated. To the I within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MC0773451 February 10,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Yan Chen, N.P. 9211 Stuart Lane, Clinton, Maryland 20735 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 2 2 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Physician/ 02/15/2010 CARLYN NORBERG BROWN 2:00AM M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Rockville Hebrew Home If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)
 PA 5. Social Security Number 8. Date of Birth 7. Age (In yrs. last birthday, **Funeral** 1 M 2 XF Hours (Month, Day, Year) 04/03/1918 Director 164-12-7278 91 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 No Rockville MD Montgomery 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? Completed by Funeral 6121 Montrose Road USA 20852 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: 3 Widowed 4 ☐ Divorced White Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Joseph Feldman Jeanette Bonham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda N. Blair - daughter 8709 Victoria Road, Springfield, VA 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🛚 Cremation 3 ☐ Removal 4 ☐ ponation 5 ☐ Other (Specifi 02/16/10 Hanover, MD 21. Signatur of Funeral Service 22. Name and Address of Facility Snowden Funeral Home Washington St, Rockville, MD 20850 Part 1. Enter the d Approximate shock, or heart fallure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death TI+RUMBOSIS Pnysician disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Jue to (or se a consequence or) Exami burial-tra that initiated events that the death certificate be exec Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box (in the past 12 months?

1 Yes 2 No
9 Unknown Day Month Year Pregnant at time of death g Unknown P.O. been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No the Hospital or Attending Physician: The law requires 3 Probably 4 Unknown Division of Vital Records, 1 Tyes is certificate has been si director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed: tor: After this certificate I the funeral director, page 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: ျ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending work? 1 Yes 2 No Investigation Could not be □ Accident Director: 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital or At within 24 hours after or To the Funeral Direct completed filled in by Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type Print) 31. Date filed (Month, Day, State 9 Registrar

DHMH 17 Rev 7/2009

LVZ

10-01400 Dana Anne Barry

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

OCME

ana Anne bany		For State Certific	icate of Death	Reg. N	
Physician		eqistrar Decedent's Name (First, Middle,Last)	2	2. Date of Death Month Da February 16,	3. Time of Death
al Examine		DanaAnne Barry	4b. City, Town, or Location of Death		4c. County of Death
	4	Facility Name (if not institution, give street and number) Washington Adventist Hospital	- Hagerstown - Takoma		Montgomery
Emand	5	Social Security Number 6. Sex 7. Age (In yrs. last			MM/DD/YYYY) 9. Birthplace (State or
Funeral Director	١	130-56-7570 _{1 M 2 XF} 37	Yrs. Months Days Hours Min.	3/21/1	972 Foreign Korea
	t	Jsual Residence of Decedent			10d. Inside City Limits
r any			wn or Location ver Spring		1 Yes 2 No
Aaryland 28a-f show 1 at once.	١		10f. Zip Code	I 10g.	Citizen of What Country?
Mary r 28a-	Director	0e Street and Number 815 Thayer Avenue #808	20910	ľ	USA
		11. Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (Spe	ecify Yes or No-	14. Race - American Indian, Black,
eath w	= 1	1 Never Married 2 Married Armed Forces?	If Yes, specify Cuban, Mexican, Puerto F	Rican, etc.)	White, etc. Asian
after d	<u></u>	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1 Yes 2 No specify:	adi dana 116	Specify: AS Lam Sb. Kind of Business/Industry
5-0036 led within 72 hours after Hygiene "natural", other than "natural", the Medical Examiner	8	10, Decedent's Education (openin) and any in-	 Decedent's Usual Occupation (Give kind of w during most of working life. DO NOT use retire 	ed)	
36 tin 72 tin 72 than "dical	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 5 +	Attorney		I.R.S.
5-003 iled withii Hygiene. Jother th	하	17. Father's Name (First, Middle, Last)	18.Mother's Name		den Surname)
21215-0036 Uld be filed within 7 Mental Hygiene anarked other than c event, the Medics	<u>8</u>	Thomas Barry	19b. Mailing Address (Street and Number or R	Spirito	r City or Town, State, Zip Code)
Should and Me 7 is ma matic en	2	19a. Informant's Name/Relationship (Type, Print) Thomas Barry/Brother	387 Violet St. Mas		
≥ and	ŀ	20a Method of Disposition 20b. Pla	ce of Disposition (Name of cemetery,	Date 2	Oc. Location - City or Town, State
Preserved in the second		1 A Burial 2 Cremation 3 A Removal from State St	matory or other place) Raymond Cem. 2/2	3/2010	Bronx, New York
Baltimore, permit. Pages 1 at Department of Hec Important: If ite Important: Important: If ite Important: Importa	1	4 Donation 5 Other Specify. 21. Si. a e of Fyneral Service Li ee	Phame and Address of Front ALD	I FUNER	AL SERVICE, P.A.
Dep	1	Mily & Kineter	9241 Columbia B	lvd.Sil	ver Spring, Md20910
Physician	Т	23a. Part I. Enter the disease, or complications that caused the death. D failure. List only one cause on each line.		respiratory arrest	Between Onset and Death
/Medical Examiner		Immediate Cause (Final disease or condition resulting in death) a Pulmonary Thromboemb Due to (or as a consequence of):	olism		
	1	Sequentially list conditions, b.			
	ner	if any, leading to immediate cause. Enter Underlying Cause			
	Examine	Culsease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
Box 68760, e death certificate be executed the artending physician and ed for use as the burial - transit	<u></u>	d	2/10/10 DML M-C-		
68760, certificate be executed mding physician and use as the bural - trans	Physician/Medical		2/19/10,BMW,MoCo		23d. Date of delivery
760, ficate be g physic s the bur	Ĕ	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnat 1 Live birth	ancy 2 Fetal death 3 Ectopic pregna	ancy	Month Day Year
Box 687 e death certifics the attending p	icia	past 12 months? 4 Pregnant at time of deal 1 Yes 2 No 9 V Unknown 9 Unknown	th 5 Other (Specify)		
Aecords, P.O. Box The law requires that the death cate has been signed by the arte page 2 should be detached for t	, y		sulting in the underlying cause given in Part I.	23e. Did tob	acco use contribute to the cause of death?
that the ned by detacl	J.	Part II. Other significant conditions continuating to doubt but necessary	, ę	1 Yes	2 No 3 Probably 4 Unknown
ords, wequires to been significations.	ğe			24a. Was an	
COrdinar II aw re thas by	Completed			perform	ned? death?
		25. Was case referred to medical	26 Place of Death (Check		
/ital	Be		ER/Outpatient 3 DOA Other Nursin	•	esidence 6 🗸 Other: Scene
of Vital Records, P.O. ing Physician: The law requires that th After this certificate has been signed by uneral director, page 2 should be detach	n: To	27. Manner of Death 28a. Date of Injury (Month, Day, Year)	28b. Time of Injury 28c. Injury at Work?	28d. Describe ho	ow injury occurred
ion ttendi death ttor: /	atio	1 V Natural 5 Pending 2 Accident Investigation	me, farm, street, factory, office building, etc.	28f Location (St	reet and Number or Rural Route Number, City
Division of Vital Records, P.O. pital or Attending Physician: The law requires that th ours after death. eral Director: After this certificate has been signed by filled in by the funeral director, page 2 should be deach	Certification:	3 Suicide 6 Could not be determined (Specify)	me, raim, street, ractory, office building, cite.	or Town, Sta	
lospita I hours unera		4 Homicide	e, death occurred at the time, date and place, and	d due to the cause	(s) and manner as stated.
Division of Vital Division of Vital To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director: After this certif completely filled in by the funeral director.	Medical	(Check only one) 2 Medical Examiner: On the basis of examination an and manner stated.	d/or investigation, in my opinion, death occurred	at the time, date a	nd place, and due to the cause(s)
10	Me	29b. Signature and title of certifier	29c. License number		29d. Date signed (Month, Day, Year)
10		JM. DE	O.C.M.E.		February 17, 2010
		30. Name and address of person who completed cause of death (Item Jack Titus MD. Deputy Chief Medical Examiner		1201	
	oto				
Regist	tate trar	EED 10 2010 A	parket		OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** February 15, 2010 01:18 AM Virginia Wood Burch /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Hospital Cheverly
Inder 1 Year | If Under 24 Hrs. | 8. Date of Birth
Inths | Days | Hours | Min. | July 31, 1948 Prince George's 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) Funeral 1 □ M 2 F Months Washington, DC 577-66-4295 Director Usual Residence of Decedent Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ary or other traumatic event, the Modical Evandary reast be notified at Charlotte Hall St. Mary's Maryland 1 ☐ Yes 2X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20622 United States 30670 Big Horn Ct. Funeral Was Decedent Ever in U.S. Armed Forces?
 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc 1 Never Married 2 X Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: ð 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Chief Operating Officer Non Profit 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Gail Smith William Wood 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 30670 Big Horn Ct., Charlotte Hall, MD 20622 19a. Informant's Name/Relationship (Type. Print) Dale F. Burch/Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Febrary 20, permit. Page Department of Important: If any Injury or once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Mechanicsville, MD Oueen of Peace Cem. 22. Name and Address of Facility Brinsfield-Echols F.H., P.A., 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 30195 Three Notch Rd., Charlotte Hall, MD 20622 MO0817 Je 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** relvic fx retorgentmen disease or condition resulting in death) /Medical Due to (as a consequence o : Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 424 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and stely filled in by the funeral director, page 2 should be detached for use as the burial-transit ately filled to by the funeral director, page 2 should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 more Month Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 □Yes 2 1No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗆 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred Iti 27. Manner of Death 28b. Time of 28c. Injury at Work? 5 ☐ Pending investigation 1
Natural 8ebruary 14201018 1 Yes 2 No 2 Accident road. 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number. City or Town, State) determined 4 🗌 Homicide LACOTA within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Hit Medical Examiner: On the basic of examination and/or investigation. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registrar

Karen Brooks, Cheverly, MD 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

32. Fegistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** BERRY 17:34 PM ENISE 2010 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** ADVENTIST MARYLAND HOSPITAL KOCKVILLE, MONTGOMERY GROVE 8. Date of Birth Month, Day, 02 23 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Min. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days 10 M 20 F NONE Yrs. MARYLAND Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County or than "natural", or items 23a or 28a-f show the Madical Examiner must be notified at Yes 2 No MONTGOMER 18310 Director limko 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code MARYLAND 208 JERMANTOWN death Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. hours after 1 Yes 2 No If Yes, Give Year or Dates: Never Married 2☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: ģ BLACK 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 72 t Department of Health and Mental Hygiene. Important: If tiem 27 is marked other than "natu any injury or other traumatic event Elementary/Secondary (0-12) College (1-4or 5+) NFAN 18. Mother's Name (First, Middle, Maiden Sumame 17. Father's Name (First, Middle, Last) BERRY RAVIS HNIONIO 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18310 TIMKO LANE, GERMANTOWN, MD 20874 THER 10 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) STERI YCLE 03/23/2010 1 4 ☐ Donation 21. Signala TII) eral Service License 22. Name and Address of Facility MEDICAL CENTER DRIVE, KOCKVILLE, MA 23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on Approximate Interval Between Onset and Death d the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, line. Immediate Cause (Final disease or condition resulting in death) TREME Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit ed by the attending physician and detached for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months?
1 Yes 2 No Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 1 🗌 Yes 3 🗌 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed Yes 2 1 🗌 Yes Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: Other: 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at Work? 27. Manner of Death Dat of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Hospital or Attending Pl
 24 hours after death.
 Funeral Director: After to Certification: Natural 2 Accident 5 Pending 1 Yes 2 No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours af To the Funeral D completely filled in 29a. Certifier 1🖒 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

State Registrar

and manner stated.

30, Name and of ress of son who completed cause of death (Item 23a) (Type, Print)

9901

1600

MEDICAL S

(Check only one)

29b. Signature and title of certifie

29c. License number D0037805

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

02/23/2010

DRIVE, ROCKVILLE, MARYLAND 20850

- BUTE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 25 per me g929 10-12-11 vt
State of Maryland Department of Health and Mental Hygiene () 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year Cornwell, Jr. Charles Lee February 25, 2010 4:50 a 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death St. Mary's Hospital St. Mary's Leonardtown If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 03/28/1943 9. Birthplace (State or Foreign Country) North Carolina 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Days Hours 1X M 2 □ F Yrs. 241-68-2258 66 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Maryland St. Mary's Callaway 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 20620 45214 Irvings Place USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White 3 ☐ Widowed 4 ₺ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Defense Contractor Analyst 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Lee Cornwell Margaret Lankford Marv 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Beaulieu/Daughter 19198 Wrightsville Rd., Bowling Green, VA 22427 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Brinsfield-Echols 102/27/2010 Charlotte Hall, MD 21. Signature Funeral Service Ricensee 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 22955 Hollywood Rd., Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if the light cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last CERTIFICATION APPROVED BY MEDICAL EXAMINER Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3

Ectopic pregnancy in the past 12 months? Month 5 ☐ Other (specify) 1 ☐Yes 2 ☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 es 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 2 No 1 ☐ Yes 2 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1**g** Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manny of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Vatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

law requires that the death certificate be executed sician and burial-trans After this certificate has been signed by the attending physician funeral director, page 2 should be detached for use as the buria After this certificate I or Attending Physician: after death. Director; After this certifice filled in by P Hospital of 24 hours a Funeral D

Physician

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
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Physician /Medical

Examiner

Baltimore, Maryland 21215-0036

3-35-1943

DOB: 3-31-P.O. Box 68760,

Records,

Division of Vital To the within 2

10 RME

David Federle, M.D.

29c. License number

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

24035 Three Notch Rd., Hollywood, MD 20636

31. Date filed (Month, Day, Year)

29b. Signature and fitle of certifier

(Check only



Registrar

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P.O. Box 68760	eath c atten for u	Physician/Medic	in the past 12 months?	Live Birth 2 Fetal de Pregnant at time of deat	eath 3 🗌	Ectopic pregnancy Other (specify)	/		Moi		Day Year	
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1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Pregnant at time of death Unknown Yes 2 No signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypertension 1 Yes 2 No 3 Probably 4 Unknown . Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed?

Yes 2 1 Yes 2 140 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No မ 1 Nnpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) To the Hospital or Attending Plantin 24 hours after death.

To the Funeral Director: After the completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Avatural 5 Pending iniury work?
1 Yes 2 No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier 🖺 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Barbara D 0065485 Supurich 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

Box 68760

P.O. I

Division of Vital Records,

State

Barbara A. Supanich.

FEB 19

31. Date filed (Month, Day, Year,

M.D.

Registrar's Signatu

1500 Forest Glen Road, Silver Spring, MD 20910

10-01327 Rosaline M. Ferna	and		or Print in Bla e of Maryland /								gible	e. 2010	06742
		1- For State Registrar		Cei	rtificate o	Deat	th		_	R	eg. No.	2010	00146
Physicia		Decedent's Name (First, Middle,L	ast)							Date of Dea Month		Year	3. Time of Death
Medical Examin	er	Rosaline Madrid 4a. Facility Name (if not institution, g	Fernandez		- T	4h City	Tours or	Location of		Month ebruary		010 County of Deatl	1700 hrs
		8777 Georgia Avenue #8				-	r Sprin		Deam			: County of Death Montgomery	1
Funeral		Social Security Number 6.	r If Under	24Hrs. 8	Date of Bi		DD/YYYY) 9. Bir	thplace (State or					
Director		575-96-4555 1	M 2KF 8	4	Yrs	Month	hs Day:	s Hours	Min.	June	16,	1925 Foreign	^{untry)} Hawaii
any	ı	10a. State 10b. County	10	Dc. City,	Town or Locat	ion							10d. Inside City Limits
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h with	era	11. Marital Status	12. Was Decedent Ev	er in U.	.S. 13. Wa	s Docode	ont of Uis	spanic Origi n, Mexican,	n? (Specif	. Voc or Ne			ican Indian, Black,
r death	틸	1 Never Married 2 Marrie	1 Yes 2 X	No					r dello Rica	u1, etc.) u1			1
s after	ል		ed If Yes, Give Year or Dates:	-41		Yes 2		specify:	-1-61			Specify: Phi	
hour "natu	Completed	15. Decedent's Education (Specify Elementary/Secondary (0-12)	College (1-4 or 5+)		16a. Deceden during m			tion (Give ki . DO NOT u		done	16b. I	Kind of Business/	ndustry
136 hin 72 e. than	亂		college (1-4 of 51)		, , , , , , , , , , , , , , , , , , ,	.						•	
5-00 ed wit sygien other	탉	Unknown 17. Father's Name (First, Middle, Lar	st)		Fruit	Sort		18.Mother's	Name (Fir	st, Middle,		Od Surname)	· —
215 be file mtal H rked o	Re	Venancio Madrid					- 1.	Julia:	na Pad	ire			
21 21 Nould and Medic every tice every time of the contract of		19a. Informant's Name/Relationship			19b. Mailing	Address					nber, C	ity or Town, State	, Zip Code)
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f she injury or other traumatic event, the Medical Examiner must be notified at once		Lyn Stoner -da	ughter									82604	
S l ar of Hea If ite	-	20a. Method of Disposition 1 X Burial 2 Cremation 3	Removal from State		Place of Dispos crematory or oth			netery,	Da	ite	20c. I	Location - City or	Town, State
Page Page ment or otl	L	4 Donation 5 Other Speci	_		zon				3/27	/2010	Phi	lippine	3
Salt ermit bepart mpor njury		2) Signature of Funeral Service Lice	ensee		22. N	ame and	Address	of Facility	McGui:	re Fu	nera	l Servi	ce, Inc.
	-	23a. Part I. Enter the disease, or con	applications that severed the	doath	1740)0 Ge	eorgi	ia Ave	enue,	N.W.	Was	hington	D.C.20012 Approximate Interval
Physician /M_dical	1	failure. List only one cause on	each line.						rdiac or res	piratory arr	est, sric	ck, or neart	Between Onset and
Examiner	1	Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequ			ated by	y Drowi	ning					Death
Sand 1	1	Sequentially list conditions	b.	01100 01	'/-		4						
	힐	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consequ	ence of	f):								
7	amıner	(Disease or injury that initiated	Due to (or as a consequ	ence of	n·								
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687 certific iding		3b. Was decedent pregnant in the past 12 months?	1 Live birth	o of do	ath =	al death	3 [Ectopic p	pregnancy			Month [ay Year
eath c	SIC	1 Yes 2 ✓ No 9 Unknov	7	e or de	atn 5 Oth	ner (Spe	cify)				1		
C true d		Part II. Other significant conditions		ut not re	sulting in the u	nderlying	g cause g	iven in Part	I.	23e. Did to	bacco	use contribute to	the cause of death?
P. C	<u></u>									1 Yes	2 🗸	No 3 Prob	ably 4 Unknown
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/ital	ומ	examiner?	Hospital: 1 Inpatient	2	ER/Outpatient			044	Nursing Ho		Reside	nce 6 🗸 Other	Scene
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Division of Vital Records, P.O. Box 68760, rat or Attending Physician: The law requires that the death certificate be ster death. The this certificate has been signed by the attending physic led in by the funeral director, page 2 should be detached for use as the bur	2	2 Accident Investiga 3 Suicide 6 Could no	28e Place of Injury	- At ho	1700 hrs ome, farm, stree	t, factory	, office be	uilding, etc.	28f.			nd Number or Ru	ral Route Number, City
Divers af	Certification:	4 Homicide determin		/Motel	I				877	or Town, S 7 Georgia		e #814, Silver	Spring, Md
			cian: To the best of my kr										
Fo the vithin fo the comple	s L		er: On the basis of examin and manner stated	ation ar	nd/or investigati	on, in my	opinion,	death occu	irred at the	time, date	and pla	ce, and due to the	e cause(s)
	ĒΓ	29b. Signature and title of certifier				290	License	number			29d. [Date signed (Mor	th, Day, Year)

To the Hospital
within 24 hours a
To the Funeral E
completely filled

31 Date filed (Month Day Year) 2010 32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) Ling Li, MD Assistant Medical Examiner

29b. Signature and title of certifier

W

State

Registrar

111 Penn Street, Baltimore, MD 21201

and

O.C.M.E.

February 14, 2010

Please Type or Print in Black Indelible, Ink. Ensure All Copies Are Legible. Amend 10ck 17 per FH Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Year 410 ANN BEVERLY GARGIULO March 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Upper Chesapeake Medical Center Bel Air Harford 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Date of Birth (Month, Day, Year) 1 □ M 2 🕱 F Months Days Hours Min. 213-48-9738 62 Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or than "natural", or items 23a or 28a-f show the Medical Experiment must be notified at 1 ☐ Yes 2 No Directo MD. Harford Pvesville Pylesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1709 Scott Road 21132 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📈 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Entities once. 1 Never Married 2 Married altimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2X No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced Specify: White 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Recruiter Retail 17. Father's Name (First, Middle, Last) Thomas Zeller 18. Mother's Name (First, Middle, Maiden Surname) Be Frank J. Gargiulo (Husband Marie Sceglia ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21132 19a. Informant's Name/Relationship (Type. Print) Frank J. Gargiulo (Husband 1709 Scott Road Pylesville, Maryland March 4, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) 2010 |Fallston, Maryland Mem. Gardens 21. Signature of Fundal Solvice Ligensee 22. Name and Address of Facility E.G. Kurtz & Son Funeral Hucklen Home, P.A. Jarrettsville, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final mutiple **Physician** disease or condition resulting in death) 10 years /Medical Due to (or as a confequence of): Examiner sequentially list on orders, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) that the death certificate be executed Due to (or as a consequence of) Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 🗆 Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 1 ☐Yes 2 No 5 ☐ Other (specify) the o 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy The performe certificate Vital 1 ☐ Yes 2 ☐ No 1 □Yes 2 No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To of сотретену filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred ision (1 Natural 2 Accident 5 Pending investigation 1 □Yes 2 □ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 29b. Signature and Itte of certifier 29c. License number 29d. Date signed (Month, Day, Year) H0067817 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Chisapeake Dr Bel AMMP BUSH 500 opa gistrar's Signature 31. Date filed (Month) 32. R State Registrar

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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2/13/2010 **Physician** 3:16p Samuel heon Gump /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Regressial Prince Georges

9. Birthplace (State or Foreign
Country)

MD haure 8. Date of Birth (Month, Day, Ye 8/3/1935 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** Months Days Hours Min M 2□ F 74 Director 218-30-3993 Usual Residence of Decedent with the Maryland 10d, Inside City Limits 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Wedical Evry, inc. west by notified at any injury or other traumatic event, the Wedical Evry, inc. west by notified at any injury or other traumatic event, the Wedical Evry, inc. west by notified at any once. 1∏Yes 2∏No Director Beltsville Prince Georges MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number US Funeral 20705 7508 Old Muirkirk Road 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐Yes 2 No Specify. Specify: 2 Black 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 9th Truck Driver Trucking 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be Bertie V. Marshall Morris Winfield Crump ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7508 Old Muirkirk Road, Beltsville,MD 20705 Nancy Diane Crump/ Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lawn Memorial Pk 2/22/2010 Rockville,MD 22. Name and Address of Facility Snowden Funeral Home 21. Signatu 246 N. Washington St., Rockville, MD 20850 Part 1. Enter the dise se, or complications that caused the deal. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Postula P Winney Embolus disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner -ower Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated expects.) Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy Month Year 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2010 Car unva - $\mathbf{m} \cdot \mathbf{n}$ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Karunu 31. Date filed (Month, Day, Year) State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Carroll Green Feb 9, 2010 1800 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Westminster Carroll Hospice Dove House Social Security Number 6. Sex 7. Age (In <u> Carroll</u> Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day,)
July 24, . Age (In vrs. last birthday **Funeral** Year) M 2□ F Months Days Min. 62 Maryland Director 212-50-4901 Usual Residence of Decedent 1947 10a. State 10d. Inside City Limits show 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the "welfcal Experient results by notified at 1 XYes 2 ☐ No Director Carroll MD Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 408 Stacey Lee Ct. 21158 USA death v 12. Was Decedent Ever in U.S. Armed Forces?

1 Xes 2 No 197 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian. Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event. 1971 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 🏖 No Specify <u>ک</u> 3 Widowed 4 Divorced 1976 White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Printer Printing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ unknown Ruth Sipes 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tammy Cowman Daughter 2340 Sandymount Rd. Finksburg, MD 21048 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Leisters Cemetery 2/18/2010 | Westminster, Maryland 22. Name and Address of Facility Pritts Funeral Home & Chapel, PA 21. Signature of Funeral Service Licens 21157 412 Washington Rd. Westminster, MD 23a. Part Center the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** disease or condition /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any least to the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Exami and Due to (or as a consequence of) Box 68760, the attending physician certificate be Physician/Medical nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Month Year 4 ☐ Pregnant at time of death 5 Other (specify) P.O. 1 □Yes 2 □No detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Lonknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 2 No 1 ∐ Yes 2 12 No 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certificants the Funeral Director is a second to the Funeral Director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Mann f Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 atural 5 Pending 1 ☐Yes 2 ☐ No investigation 2 ☐ Accident filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🔲 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2.

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Registrar

29b. Signat

e and title of certifie

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

X

32. Registrar's Signature

29c. License number

Street WESTHILLSTERIND 21157

29d. Date signed (Month, Day, Year)

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			. For	State of Ma	arylan	-	artment of h		Mental Hyg	giene	0010	06746
			State Registrar			Ce	rtificate of L	Death	F	Reg. No	2010	00140
	Physicia		1. Decedent's Name (First, Middle, La	,					2. Date of Dea Month Februar	De	2, 2010	3. Time of Death 4:18 p.M.
	Medic		Mary Madgalan 4a. Facility Name (If not institution, giv				4h City Town o	r Location of Death			C. County of Death	
	Examin	er	St. Mary's Hosp	ŕ			Leonard				t.Mary's	
	Funeral		5. Social Security Number 6.	Sex 7. Age	e (In yrs. la	ast birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	h	9. Birtl	hplace (State or Foreign
	Director		216-30-4171 Usual Residence of Decedent	1 □ M 2 🏋 F	75	Yrs.	Months Days	Hours Min.	07/08/1	, Year) 934	Mary	ntry) land
	/land f show ed at	tor	10a. State 10b. County		10c. City	y, Town or Lo	ocation					10d. Inside City Limits
	r 28a- notifie	Funeral Director	Maryland St. Mar	y's	Lexi	ington	Park 10f. Zip Code			10a C	itizen of What Cou	1 ☐ Yes 2 🔀 No
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	ems r mu	nu	11. Marital Status	12. Was Decedent E	ver in U.S	3. 13.	Was Decedent of H	lispanic Origin? (Sp	ecify Yes or No-	0111	14. Race - Amer	
36	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and horltal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☒ If Yes, Give	No		If Yes, specify Cuba 1 ☐ Yes 2 X No		o Rican, etc.)		Black, White Specify:	
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Maryland 21215-0036	shoul and l		19a. Informant's Name/Relationship (Type, Print)		19b. Mail	ing Address (Street	and Number or Ru	ral Route Number	; City o	r Town, State, Zip	Code)
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altimore	t of H If ite or oth		20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation 3 [Removal from State	20b. P	lace of Disp emetery, cre	osition (Name of matory or other plac	ce)	Date	20c. L	ocation - City or	Town, State
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	ابا ع) د ا		30. Name and address of person who	completed cause of d	eath (Item	23a) (Type.		26842		ا حر	rvary	Ja, auto
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Registrar Reg. No. 2. Date of Death 1 Decedent's Name (First Middle Last) 3. Time of Death Physician/ Month M Rosalie Williams Green February 2010 0535 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Silver Spring Holy Cross Hospital 8. Date of Birth (Month, Day, Year) 1942 Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Funeral Days Min Months 1 M 2 X F Hours DC 68 Director 578-56-0188 Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10a State 10b. County 10c. City. Town or Location at Director item 27 is marked other than "natural", or items 23a or 28a-f s other traumatic event, the Medical Examiner must be notified 1 X Yes 2 I No Washington DC 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 23a Funeral 20017 United States 4041 7th Street NE 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married ģ Maryland 21215-0036 African 1 Yes 2 No Specify: 3 Widowed 4 X Divorced Completed Year or Dates American 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done of life, DO NOT use retired) (Specify only highest grade completed) during most of working College (1-4 or 5+) Elementary/Seconday (0-12) Il Hygiene. Secretary Government Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) should be file h and Mental F 7 is marked of ٥ Rev. David L. Williams, Naomi Singleton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Maria Green/ Daughter 3415 Manderes Place Springdale, Maryland 20774 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State Lee's Crematory 3/8/2010 Clinton, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Stewart Funeral Home, Inc. Funeral Service License 21. Sia 4001 Benning Rd. NE Washington, DC Approximate Interval Between Onset and Death the the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Physician/ MRSA Sepsis Medical Due to (or as a consequence of): Examiner Febrile Neutropenia, Recurrent Pleural Effusion Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) burial-transit Cause (Disease or iinjury that initiated events Metastatic Small Cell Lung Cancer Due to (or as a consequence of) resulting in death) Last physician s the burial Be Completed by Physician/Medical certificate be attending p IF FEMALE: been signed by the attendin should be detached for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 L. Fetal use.
Pregnant at time of death in the past 12 months? 1 ☐ Yes 2 ☐No Month Day 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2 🗌 No 3 🗔 Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? page 2 s has autopsy performed? Yes 2 X No 2 🗌 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 X No 1 Npatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending P 24 hours after death. Funeral Director: After t (Month, Day, Year) injury X Natural 5 Pending 1 Yes 2 No Investigation Accident completed filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

State Registrar

Baltimore,

Box 68760

P.0.

Division of Vital Records,

1500 Forest Glen Road POTHU RAJU NAGABHYRU, MD 31. Date filed (Month, Day, Year) 2 2 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

29c. License number

D63639

29d. Date signed (Month, Day, Year)

20910

02/17/10

Silver Spring, Md.

Please Type or Print in Black Indelible Ink. Erisure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ Day **GEORGE** M Τ. GRAY FEBRUARY 10 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SOUTHERN MARYLAND HOSPITAL CLINTON PRINCE GEORGE'S 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth 6. Sex **Funeral** Days (Month, Day, 1 **X** M 2 □ Director 579-34-0054 1927 82 WASHINGTON, DC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 3a or 28a-f sl 1X Yes 2 ☐ No PRINCE GEORGE'S MD BRANDYWINE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a must be Funeral 14520 OWINGS AVENUE 20613 USA "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 XMarried 1 X Yes If Yes, Give 2 NoARMY Maryland 21215-0036 1 ☐ Yes 2 T☐ No Specify: Specify: BLACK 3 Widowed 4 Divorced Year or Dates er than "natura the Medical E 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) it. Page 1 and 2 should be filed withinthent of Health and Mental Hygiene retart: If item 27 is marked other the njury or other traumatic event, the 12TH ACCOUNTANT COVERNMENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ GEORGE T. GRAY SR. ESTHER MILLER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BESSIE F. GRAY/WIFE 14520 OWINGS AVENUE BRANDYWINE, MARYLAND 20613 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of Important: If it any injury or o Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) MORRIS COMM. CEME. 2/20/2010 HUME, VIRGINIA 22. Name and Address of Facility ture of Fireral Service Licensee J. B.JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Physician/ PULMONARY FIBRUST disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner KPIRATION PHEUMONIA Sequentially list conditions, it airy, leading to immediate cause. Enter Underlying Examine Due to (or as a sonsequence of). Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
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2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) 29b. Signature and title of certifier 29c. License number

Registrar
DHMH 17 Rev 7/2009

State

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(NATYLAND (AUSPITAL

31. Date filed (Month, Day, Year)

30. Name and address of person who completed duse of death (Item 23a) (Type, Print) ANILE MAHAJAW. MD

7503

CENTER

32. Registrar's Signature

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Funeral

Director

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Division of V	after dea Director	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could no determine		28e. Place of Injubuilding, etc	ury - At ho	ome, far	m, street, fac	tory, offic	ce	
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FEB 19 2010

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) Physician 10:00A M 2010 Feb. 8 Matthew Allen Hinton /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges 5118 Barto Avenue Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday, Vear Yrs. '39Virginia April 29, 70 223-44-4237 Usual Residence of Decedent 10d. Inside City Limits 10a, State 10c. City. Town or Location 10b. County TX Yes 2 □ No Director Camp Spring Prince Georges MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA uneral 5118 Barto Avenue 20746 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1.5746 2.51No 1957 14. Race - American Indian, 11. Marital Status Black, White, etc. Specify: Black 16b. Kind of Business/Industry ssional U. S. Airforce me (First, Middle, Maiden Surname) Lucille Dailey ural Route Number, City or Town, State, Zip Code) amp Springs MD_20746 20c. Location - City or Town, State eb. 17 Riverdale, MD atney's Funeral Home, Inc. Washington, DC 20011 ac or respiratory arrest, ate 23d. Date of delivery Month Year Dav 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a, Was an autopsy performed?

1 Yes 2 No eath (Check only one) Home 5X Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) ce, and due to the cause(s) and manner as stated. curred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) Maryland Wan Zama MD 9200 Basil Court 31. Date filed (Month, Day, Year) 37. Registrar's Signature_ State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Registrar

races

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.

Physician
/Medical Examiner
Funeral
Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland ? is marked other than "natural", or Items 23a or 28a-f sho traumatic event, the Medical Examirer must be notified at is marked other of Health a ltem 27 is Jo.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

law requires that the death certificate be executed

Box 68760

P.0.

Division of Vital Records,

1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year 9:30 am February Sawa Takahashi Huddleston 11, 2010 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Silver Spring Montgomery Holy Cross Hospital If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Days 1 □ M 2 🛛 F Yrs. 85 Japan 212**-**68-6137 pril_05. Usual Residence of Decedent 10h County 10c. City, Town or Location 10d. Inside City Limits 1 ☐Yes 2 🛛 No Directo Silver Spring Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 12705 Montclair Drive 20904 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2 X No Specify: ð Specify: 3 X Widowed 4 □ Divorced Asian Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Masaru Takahashi Tose 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 225 Cannon Ball Way, Odenton, Maryland 21113 Stanley Huddleston - Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages Department of Important: If It any injury or o 1 ☐ Burial 2 ☑ Cremation 3 ☑ Removal from State 4 Donation 5 Dother (Specify) Arlington Natl. Cem. 03/12/2010 Arlington, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. Will 11800 New Hampshire Ave., Silver Spring, MD 20904 m01294 23a Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cardiopulmonary Arrest disease or condition resulting in death) Due to (or as a consequence of): Coronary Artery Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting indepth), act Examine Due to (or as a consequence of) Dehydration signed by the attending physician and I be detached for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Physician/Medical Myelodysplastic Syndrome IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 1 Tyes 2 X No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ icate has been significate has peen significated by page 2 should by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 ☐ Yes 2 ☐ No 1 ☐Yes 2 🛛 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To 28a. Date of Injury (Month, Day, Year) Hospital or Attending Pl 24 hours after death. Funeral Director; After the 27. Manner of Death 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 24 hours a 29a. Certifier 1 🖸 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mayber stated. (Check only one) To the twithin 24 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sirak Hagos Lemma,

31. Date filed (Month, Day, Year)

MD,

3. Registrar's Signature

D0065069

1500 Forest Glen Road, Silver Spring, Maryland 20910

February 11, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar AMEND#23aIperMD, 2/19/10, BW, McCo Certificate of Death Reg. No.? 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Joseph Austin Hamilton Jr. February Day 6, 2010 3:15 Α Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Montgomery Bethesda Suburban Hospital If Under 1 Year If Under 24 Hrs. 5. Social Security Number 578-22-5838 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Min. 1 X M 2 □ F Months Hours 12MT4PT923 Maryland Director 86 Usual Residence of Decedent or 28a-f shov s notified at shov 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director MD Bethesda Montgomery 1 ¥ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? "natural", or items 23a o Funeral United States 20817 9700 Holmhurst Road 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 \sum No 194

If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black. White, etc. 2 □ No 1942-Completed by 1 Never Married 2 Married should be filed within 72 hours after Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: Specify: 3 Divorced 4 Divorced 1946 Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Civil Aeronautics Elementary/Seconday (0-12) College (1-4 or 5+) Board Director Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Austin Hamilton Eleanor Brown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9700 Holmhurst Rd. Bethesda, MD 20817 19a. Informant's Name/Relationship (Type, Print) Mary Hamilton / Spouse Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 \square Burial 2 ot X Cremation 3 \square Removal from State 4 \square Donation 5 \square Other (Specify) 2/18/2010 Falls Church, VA National Crematory 22. Name and Address of Facility Joseph Gawler's Sons Inc. Signature of Funeral pervice Licensee 5130 Wisconsin Ave. NW Washington, DC 20016 23a. Part 1. Enter the disease, or complications that clused the death, shock, or heart failure. List only one cause on each line. ASDITATION Pneumonia r complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Weeks Physician Medical resulting in death) Due to (or as a consequence of): Dysphagia Aspiration Examiner Sequentially list conditions, Examiner Remore Cerebrovascular Accident If any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events been signed by the attending physician and should be detached for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Remote Gerebrovascular Accident that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Pregnant at time of death Yes 2 No 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ The law requires Acute Renal Failure, Urinary Tract Infection, Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of Paroxysmal Atrial Fibrillation, CA Prostate, 24a. Was an has page 2 autopsy Metastatic Liver and Lung Disease performed? Yes 2 A No this certificate 1 Yes 2 No Vital Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2X No 1 Tes ည 1 X Inpatient 2 ER/Outpatient 3 DOA ð 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After Hospital or Attending Natural 5 Pending Division 1 Yes 2 No after death Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined e Funeral 1 🛣 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) the 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 02/16/2010 29c. License number D17656 7007 M.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

FEB 19 2010

Tipaporn Woodward MD 5530 Wisconsin Ave. #550 Chevy CHase, MD 20815

82. Registrar's Sigr

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 8:00 am February 17, 2010 Roscoe Leon Hines /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Montgomery 15309 Good Hope Road Silver Spring 8. Date of Birth (Month, Day, June 27, Birthplace (State or Foreign
Country) 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 5. Social Security Number Funeral 1 **X** M 2 □ F Months Days Hours South Carolina 69 Director 250-60-3623 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ir than "natural", or Items 23a or 28a-f show the Medical Examinar must be notified at 1 ☐ Yes 2 X No Director Silver Spring Maryland Montgomery 10g, Citizen of What Country? 10e. Street and Number 10f. Zin Code 20905 U.S.A. 15309 Good Hope Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 1966-14. Race - American Indian, 11. Marital Status Black, White, etc. 1 **X** Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗶 No Specify. Completed by Specify. 3 ☐ Widowed 4 ☐ Divorced Black 1968 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Small Business Administration Federal Government item 27 is marked othe other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 1 and 2 should be fill Health and Mental H Be Evelun Groom Roscoe Hines, Sr. ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health tem 27 i 15309 Good Hope Road, Silver Spring, Maryland 20905 Helen G. Hines-Spouse 20c. Location - City or Town, State 20a. Method of Disposition . Pages 1 tment of H rtant: If ite niury or o 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or once. 02/23/2010 Silver Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cem. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Esophageal Cancer disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of) P.O. Box 68760, physician Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year 5 ☐ Other (specify) signed by the s 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗶 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of autopsy page perform rmed? 2 No 1 ☐ Yes 2 ☐ No 1 □Yes director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 M Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending 1 X Natural 5 ☐ Pending investigation nours after death.

neral Director: A
y filled in by the fc. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospital c within 24 hours at To the Funeral D completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 1 10 D64983 February 18, 2010

Registrar
DHMH 17 Rev 1/2001

varke

MD, 2101 Medical Park Drive, Suite 200, Silver Spring, MD 20902

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Kashif Alam Firozvi.

FEB 19 2010

31. Date filed (Month, Day, Year)

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u	Funeral Director		219-01-0639	M 27€ F		Yrs.	Months Days	Hours	Min.	Date of Birth (Month, Day, ct 3,	1921 Ma	rthplace (State or Foreign country) aryland
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	er deat items	uner	11. Marital Otatao	2. Was Decedent Armed Forces?		13.	Was Decedent of H If Yes, specify Cuba	lispanic Or an, Mexical	igin? (Specif n, Puerto Ric	y Yes or No- an, etc.)	14. Race - Am Black, Wh	
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land	ld be filk ental H ked oth ic even	To Be	17. Father's Name (First, Middle, Last) Stephan A. Boone						•	îrst, Middle, N rabill	faiden Surname)	
Maryland	2 shoul and M is mar	F	19a. Informant's Name/Relationship (Type		I .						City or Town, State	
re, ⊾	1 and Health tem 27 other tr		Nancy E. Harrell, d 20a. Method of Disposition	augnter			5 Arnold psition (Name of matory or other place)	<u>.</u>	West		20c. Location - City of	
Baltimore,	Pages ment of ant: If if ury or		1 Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	moval from State	1		matory or other place Methodis		3/4/20	10	Upperco,	MD
Bait	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modifical Examination to rottled at once.		21. Signature of Funeral Service Licenses	Sul m			2. Name and Addre		. 1.14	ers-Dui estmins	rboraw Fur ster, MD 2	eral Home
			Part 1 Enter the disease, or complication or heart failure. List only one	ations that caused	the death. Do	- !			_			Approximate Interval Between
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	ficate by	edical	↓ d.									
Box 687	leath certificate attending physi i for use as the t	an/Me	23b. was decedent pregnant	c. If yes, outcome	of pregnancy 2 Petal death	3[∃Ectopic pregnanc	ev			23d. Date of d	,
Ö	the dea y the at ched fo	Physician/Medic	in the past 12 months? 1 □Yes 2 No 9 □ Unknown	4 ☐ Pregnant a 9 ☐ Unknown	t time of death		Other (specify)				Month	Day Year
S, P.	Physician: The law requires that the death certificate this certificate has been signed by the attending physral director, page 2 should be detached for use as the	by Ph	Part II. Other significant conditions conti	ibuting to death be	ut not resulting in	n the u	nderlying cause giv	en in Part I	1.		L _ /	to the cause of death?
Records,	w requir s been s should									1 ☐ Ye	^	Probably 4 Unknown autopsy findings available
Re	hysiclan: The law his certificate has t I director, page 2 s	Completed								autops perforn	y prior to ned? death	completion of cause of
Vital	siclan: certific rector,	Be	25. Was case referred to medical examiner?	spital:			oth SELDON Oth			Check only on	9)	
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Division	ttendir death. stor: Af	icatic	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be					Yes 2		Location (Ct	root and Number of	Turn I Pourto Alumahor
Div	cal or Attences after death	Certification: To	4 ☐ Homicide determined	building, et	S. (Specify)	, Su	eet, lactory, office		201	City or Towr	n, State)	Rural Route Number,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical	29a. Certifier 1 Certifying Physi (Check only one) 1 Medical Examine	cian: To the best er: On the basis o and manner sta	f examination ar	e, deat nd/or in	th occurred at the tinvestigation, in my	me, date a opinion, de	nd place, an ath occurred	d due to the cat the time, d	ause(s) and manner ate and place, and d	as stated. ue to the cause(s)
		Me	29b. Signature and title of certifier				29c. Licens			1	9d. Date signed (Mo.	nth, Day, Year)
	MSL		The Wag		ND	·T	D00	617	55		2 15 10	
	5		30. Name and address of person who com ITEMALATHA NA	ipleted cause of d	,	(Type,	OOA PO	DIE	RD N	/ESTM	INSTER	MD 21157
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav Year Physician/ 1:45 A 2010 Virginia M. Huff February Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Mary's Leonardtown St. Mary's Nursing Center 8. Date of Birth
(Month, Day, Year)

December 6, 9. Birthplace (State or Foreign Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 83 Days Country)
Washington, DC 1 □ M 2 🛣 Months Hours Min. ,1926 Director 579-38-2002 Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10b. County 10c. City. Town or Location Director 1 Yes 2 No Charlotte Hall St. Mary's Maryland 10e. Street and Number 10g. Citizen of What Country? r items 23a or iner must be n ò Funeral with 1 20622 United States 12665 Norwood Drive Page 1 and 2 should be filed within 72 hours after death went of Health and Mental Hygiene. Fant: If item 27 is marked other than "natural", or items ury or other traumatic event, the Medical Examiner munor or other traumatic event. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. þ 1 ☐ Yes 2 X No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: Specify: 3x Widowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) At Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Margaret (Unknown) William May 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12665 Norwood Dr., Charlotte Hall, MD 20622 Kathryn L. Connors/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State March 9, permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cem! 2010 Cheltenham, MD 21. Signat re Fune al Service Licens 22. Name and Address of Facility Brinsfield-Echols F.H., P.A., M00817 PO Box 128, Charlotte Hall, MD 20622 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final disease or condition Physician/ 257 Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury that initiated events resulting in death) Last and the burial-tran Due to (or as a consequence of): physiciar Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as IF FEMALE: yes, outcome of pregnancy

☐ Live Birth 2 ☐ Fetal death
☐ Pregnant at time of death nse 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy ned by the atten detached for u in the past 12 months?
1 ☐ Yes 2 No Month 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ certificate has been sign irector, page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 1 Yes 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 S Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 2 No injury 1 R Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide by determined City or Town, State)

24 hours after dear filled within 2

To the I

comple

State

Registrar

Medical

29a. Certifier

only one)

29b. Signature and

30. Name and add s of person who complety James Jarboe, 31. Date filed (Mort)

Hollywood, MD 20636

cause of death (Item 23a)

🎦 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29d. Date signed (Month, Day, Year)

			State of Maryland	-	artment of H			21111	06755
			Registrar 1. Decedent's Name (First, Middle, Last)		Tillicate of t	Dealli	2. Date of Dea	Reg. No(U	3. Time of Death
	Physici:		Alaina Yvonne Herbert				Month Februa	ry 18, 201	
man ,	/Medic Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death		4c. County of Dea	ath
gue"			515 Susquehanna Avenue 5. Social Security Number 6. Sex 7. Age (In yrs. las	-4 l-2-411	Pe If Under 1 Year	erryville I Under 24 Hrs.			Cecil
	Funeral Director		5. Social Security Number 6. Sex 7. Age (<i>In yrs. las</i> 1 M 2 F 45	Yrs.	Months Days	Hours Min.	8. Date of Birt (Month, Da Feb. 2	y, _{Year)}	rthplace <i>(State or Foreign</i> Country) alifornia
			Usual Residence of Decedent	T- 1			100. 2	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
	faryla f shov	or		Town or Lo					10d. Inside City Limits 1 X Yes 2 □ No
	r 28a-	Director	Maryland Cecil		10f. Zip Code	yville		10g. Citizen of What C	Country?
	th with 23a o	ralD	515 Susquehanna Avenue			21903		U.S.A	•
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, its Medical Evarities in must be retified at once.	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 □Yes 2☑No	ispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)	- 14. Race - Am Black, Whi	
9	2 hour atural	ted k	15. Decedent's Education	16a. Dece	dent's Usual Occup	ation		16b. Kind of Business	
215	thin 72 ie. ian "na i.Medii	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)		kind of work done on DO NOT use retired	,	king	Harford Me Hospital	morial
121	led wir Hygien her th nt, the	Col	Twelve Years 17. Father's Name (First, Middle, Last)	НС	ospital E		o (First Middle	Havre de G Maiden Surname)	race.Maryland
Baltimore, Maryland 21215-0036	ld be fi ental H ked ot ic ever	To Be	Thomas Leroy Herbert			16. WOUNER'S INAM		lary Sharer	
ary	shou and M is mar	_	19a. Informant's Name/Relationship (Type. Print)	19b. Mailir	ng Address (Street	and Number or Ru	ıral Route Numbe	er, City or Town, State,	Zip Code)
<u>ک</u>	and 2 lealth m 27 l		Janet M. Horner (mother)		Box 385,			 	1902
Jor.	ages 1 nt of H :: If ite		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Placent	netery, cren	sition (Name of natory or other plac	re)	Date	20c. Location - City o West Chest	er,
ij	artme artme ortani injury		4 □ Donation '5 □ Other (Specify) K . A . 21. SignAture of Funeral Service Li ens. e	22	S & Co.,]	ss of Facility		Pennsy	
ä	Dep Imp any		23a. Part 1. Enter the disease, or complications that caused the death.		.ee A. Pai <u>Per</u> i	tterson & ryville,	Marylan	neral Home d 21903-07	66
	Physician		shock, or heart failure. List only one cause in each line. Immediate Cause (Final	Do not en	er the mode of dyn	ig, sucii as cardiac	or respiratory ai	nest,	Approximate Interval Between Onset and Death
	/Medical		disease or condition resulting in death) a. Due to (or as a consequent of the conse	nce of):					
	Examiner	<u>.</u>	Sequentially list conditions, b.						
	uted 1 Insit	Examiner	if any, leading to immediate Due to (or as a consequer cause. Enter Underlying Cause (unsease or injury	nce or):					
oʻ	e exect an and rial-tra	Exa	that initiated events c. Due to (or as a consequent presulting in death) Last	nce of):					
8760,	icate be executed physician and s the burial-transit	dical	d						
Box 6	leath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnance					23d. Date of d	elivery
	death e atte	sicia	in the past 12 months? 1 □ Yes 2 No 1 □ Yes 2 No 1 □ Yes 2 No		☐ Ectopic pregnanc: ☐ Other <i>(specify)</i>	у		Month	Day Year
P.O.	uires that the de signed by the a	Phy	9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulti	ing in the u	nderlying cause give	en in Part I	23e Did to	obacco use contribute	to the cause of death?
Records,	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	ted by	Tattii. Other algimicant contained contributing to death but not result		machying cause giv	CITILIT CITI.	1 🗆 1	100	Probably 4 Unknown
3ec	e law r has be je 2 sh	Completed					24a. Was autop	an 24b. Were a prior to rmed? death?	autopsy findings available o completion of cause of
_	hysician : The la his certificate ha I director, page 2		25. Was case referred to medical			26. Place of Dea	1 □Yes	2 No 1 □Ye	
<u></u>	nysicia nis cer direct	lo Be	examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ EF	R/Outpatier	nt 3 DOA Othe	or		dence 6 ☐ Other (Sp	pecify)
Division of	r Attending Phy er death. rector: After thi by the funeral o	ion:	1 XNatural 5 ☐ Pending (Month, Day, Year)	8b. Time of Injury	Worl		28d. Describe I	now injury occurred	
/ISIC	Attenc death ctor: by the	ficat	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury - At hom building, etc. (Specify)	e, farm, str		Yes 2□No	28f. Location (5	Street and Number or I	Rural Route Number,
á	tal or s after al Dire	Certification: To	4 Homicide determined building, etc. '(Specify)				City or Tov	vn, State)	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director. After this certifics completely filled in by the funeral director, p	Medical	29a. Certifier (Check only one) 1 > Certifying Physician: To the best of my knowledge of the deciral Examiner: On the basis of examination and manner stated.						
	To the comp	Me	29b. Signature and title of certifier	.~	29c. Licens	e number		29d. Date signed (Moi	nthi Day, Year)
			16/6-0		120.	05644	9	2/19	110
	1		36. Name and address of person who completed cause of death (Item 2	N. E	Bridge 5	+. 3rd F1	oor E	1Kton M	021921
ŧ	Sta Registr		31. Date filed (Month, Day, Year) FEB 2 2 2010 32. Registrar's Signatur	ie .					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) Francis Kenneth Joseph 2 Date of Death Month Physician/ 6:00 aM 2010 February Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery 01ney Montgomery General Hospital 9. Birthplace (State or Foreign Country) Trinidad 7. Age (In yrs. last birthday) 76 Yrs. If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number Funeral 1 🔀 M 2 🗆 F Months Days Hours Min. (Month, Day, 084-48-3976 Director Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 🖾 Yes 2 🗌 No MD Silver Spring Montgomery 10e. Street and Numbe 10f. Zin Code 10g. Citizen of What Country? Funeral 20906 Trinidad 14355 Georgia Ave 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, an "natural", or iter Medical Examiner Armed Forces? Black, White, etc. or, 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 x No Specify: Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filled within 72 t. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ne any injury or other traumatic event, the Medic once. (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Records Manager Records Mgmt. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Drucilla Knutt ည Francis Joseph 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14355 Georgia Ave #102 Silver Spring, MD 20906 Victoria Joseph, Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State FT Lincoln Crematory 2/22/2010 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Simple Tribute 1040 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Immediate Cause (Final Approximate Interval Between Onset and Death Physician/ Cardio pulmonary disease or condition Medical resulting in death) Due to (or as a consequence of) 3 days Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to (or as a consequence of): The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical attending ph IE EEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown Yes 2 No 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Jinknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No 2 N Yes Physician: Be (25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death . Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 🗌 No Accident Suicide Investigation

Box 68760 P.O. Records. Division of Vital To the Hospital or Attending Privitin 24 hours after death.

To the Funeral Director; After it completed filled in by the funeral

6 Could not be

determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Montgoren

4 Homicide

29b. Signature and title of certifier

Kinnind

Day, Year)

29a. Certifier (Check

Medical

Registrar DHMH 17 Rev 7/2009

State

Hosp ital

Geren

. Registrar's Signat

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D68658

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Physician
/Medical
Examiner

Funeral Director

Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a Marical Examinan portaining at

Be Completed by Funeral Director

မ

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner To the Hospital or Attending Physician; The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760, within 24 hours after death.

To the Funeral Director; After this certificate has been completely filled in by the funeral director, page 2 should

For State Registrar		State of Ma	-	epartme <i>Certifica</i>			Mental Hy	giene Reg. No	010	06757
Registrar Decedent's Name	e (First, Middle, Las	st)					2. Date of De	eath		3. Time of Death
	JANITA JA						Month	Day 5/2010	Year	1:00 A M
		e street and number)		4b. Ci	ity, Town, or	Location of Death		-	County of Deat	
	-	untry Blvo	. F		licott			Ho	ward	
5. Social Security N	umber 6. S	ex 7. Ag	e (In yrs. last birt	nday) If Un	der 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Bi	rth	9. Bir	thplace (State or Foreign
220-30-	7189	□м Ж□ ғ	75	rs. Month	ns Days	Hours Will.	08/18/	/1934	M	
Usual Residence of			10.03.7							10d, Inside City Limits
10a. State	10b. Counfy		10c. City, Town							1% Yes 2 No
MD	Howard		Ellico							•
10e. Street and Nur				10f.	Zip Code			10g. Citiz	en of What Co	ountry?
8874 B 1	l'own & Co	untry Blvd			21043			USA		
11. Marital Status	T.E.	12. Was Decedent Armed Forces?		13. Was De If Yes, s	cedent of Hi specify Cuba	spanic Origin? (S n, Mexican, Puert	pecify Yes or N o Rican, etc.)	0- 1	 Race - Ame Black, White 	
1 ☐ Never Marri	ed 2X Married	1 ∐Yes 2 🔀 i	No	1 □Yes	2 No	Specify:			Specify:	_
3 Li Widowed	15. Decedent's Ed	Year or Dates:	16a	Decedent's U	Isual Occup	ation		16b Kir	B1 ad of Business	.ack /Industry
	cify only highest gra	de completed)		(Give kind of life. DO NO	work done of	luring most of wor	king	7	vard Co	-
Elementary/Seco	endary (0-12)	College (1-4or 5	· _	s Atte				1	olic Sc	_
17. Father's Name	(First, Middle, Last)		1 100	5 ALLEI	ucant	18. Mother's Nan	ne (First, Middle	e, Maiden S	Surname)	
Richard	Irvin Th	omac				Hattie	Greene			
	ame/Relationship		19b.	Mailing Addr	ess (Street a	and Number or Ru		ber, City or	Town, State,	Zip Code)
Washingt	ton Jacks	on – husba	and 88	74 B To	own &	Country	Blvd. F	allico	ott Cit	y, MD 21043
20a. Method of Dis			20b. Place of cemeter				Date		cation - City or	
	☐ Cremation 3 ☐ 5 ☐ Other (Specification)	Removal from State				1	-2010	0-7.		7/15
	ineral Service Licer		Locust			4	nowden		mbia,	
	~ 0/8 n	A	_			hington				
23a, Part 1, Enter t	disease, or rom	plications that caused	the death. Do r						re, m	Approximate
shock, or hea	irt failure. List only	one cause on each li	ne.			3,				Interval Between Onset and Death
disease or condition resulting in death)		, a	c Malnut		<u> </u>					years
,			a consequence of		/ mal.	absorptio	nn -			yea rs
Sequentially list co	nditions.	D	a consequence of		/ Iliai	SUSCIPLI	71.1			усать
if any, leading to im cause. Enter Unde Cause (Disease or	erlying arinjury	•	•	•	for	malabsor	otion			years
that initiated events resulting in death)	5	U	a consequence				3 62 611			1
		d								
IF FEMALE: 23b. Was deceden	t pregnant	23c. If yes, outcome							23d. Date of de	elivery
in the past 12	months?	1 ☐ Live birth 4 ☐ Pregnant a	2 ☐ Fetal death at time of death	3 L Ectop 5 Dother	ic pregnanc (specify)	y 			Month	Day Year
9 Unknown		9 🗌 Unknown						-		
Part II. Other signi	ficant conditions	contributing to death b	out not resulting in	the underlyir	ng cause giv	en in Part I.	23e. Dio	l tobacco u	se contribute t	o the cause of death?
							1 🗆]Yes 2[X No 3□ F	Probably 4 ☐ Unknown
							24a. Wa	ıs an	24b. Were a	utopsy findings available
							aut per	opsy formed?	death?	completion of cause of
OF Was some refer	read to madical					00 Di(D	1 Tes		l 1∐Ye	s 2□No
25. Was case reference examiner?		Hospital:	ent 2 ER/Ou	trationt 2 F	1 DOA Oth	26. Place of Dea			C Other (C-	- a (f. s)
27. Manner of Dear		28a. Date of Inju	ury 28b.	ime of	IDOA	4 LI Nuising F	lome 5 Re			ecity)
1 Natural 2 Accident	5 Pending	(Month, Da	ay, Year)	njury M	28c. Injur Worl	(? Yes 2 □ No				
3 🗌 Suicide	6 Could not b	e 28e. Place of Inj	ury - At home, fa	rm, street, fac						Rural Route Number,
4 Homicide	getermine@	building, e	c. (Specify)					own, State		
29a. Certifier	1 Certifying Pi	nysician: To the best	of my knowledge	, death occu	rred at the ti	me, date and plac	e, and due to the	ne cause(s)	and manner	as stated.
(Check only one)	2☐ Medical Exa	miner: On the basis of and manner st	of examination an	d/or investiga	ition, in my o	pinion, death occ	urred at the tim	e, date and	I place, and du	e to the cause(s)

State Registrar 29b. Signature and title of certifier

Month, Day, Year)
FEB 19 2010

DHMH 17 Rev 1/2001

3

ed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2010 February Carolyn Ann Johnston 12:12 a.Mn Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** St. Mary's Hospice House of St. Mary's <u>Callaway</u> 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 🏻 F Months Hours Min. (Month, Day, Year) 10/19/1948 Director inois 334-40-7443 61 Usual Residence of Deceden ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location 72 hours after death with the Maryland Director 1 Yes 2 X No Maryland St. Mary's Drayden 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 20630 18625 Cherryfield Road United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. "natural", or ş 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: If Yes, Give Year or Dates Specify: 3 Widowed 4 Divorced Completed White other traumatic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed, (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 7 hand Mental Hygiene. 7 is marked other than marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12 Management Analyst Civil Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Robert Bangert Eunice Daniels 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh.
Department of Health an
Important: If item 27 is
any injury or other trau Edward Johnston/Husband 18625 Cherryfield Road, Drayden, MDBaltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Our Lady's Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 02/25/2010 | Leonardtown, MD Signal red Funeral Service Libensee
Edward N. Brinsfield, 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Jr. M00052 22955 Hollywood Road, Leonardtown, MD Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Colorectal Cancer Metastatic Pnysician years disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter underlying Examiner Due to (or as a consequence of) burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last physician s the burial Physician/Medical certificate be P.O. Box 68760 attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
g ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ♣ No
9 ☐ Unknown Month Year Day the signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 2 should certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 1 Yes Yes 2 No or Attending Physician: funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospice House examiner? Hospital: Other: 2- No 1 🗌 Yes မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🕅 Other (Specify) s after death. I Director: After this o 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work?
1 Yes 2 No Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by determined To the Hospital o within 24 hours af To the Funeral Di completed filled in Medical 29a. Certifier 1- 🗠 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) DUZZ bene 050686 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gurdeep S. Chhabra, M. D. 23415 Three Notch Road, California, MD 32. Registrar's Signature

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Lillian 3:35 P Levy Februar 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery Suburban Hospital Bethesda If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number . Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year pril 9, 1 9. Birthplace (State or Foreign **Funeral** 185-09-0535 1 □ M 2 🔽 F 91 Director ΡÃ 1918 Usual Residence of Decedent f show item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland Director 1 A Yes 2 □ No Bethesda Montgomery MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 20816 U.S.A. 5101 Ridgefield Drive 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 Yes Maryland 21215-0036 1 Yes 2 No White Specify: Specify: 3 ¥ Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene, is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) <u>Homemaker</u> Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Celie Levin Joseph Levin Page 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health aitem 27 i 245 Birch Drive Lafayette Hill, Stanford Levy/Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o 1 🔀 Burial 2 ☐ Cremation 3X Removal from State 2/18/2010 Philadelphia, PA 4 ☐ Donation 5 ☐ Other (Specify) Har Nebo Cemetery 22. Name and Address Derazansky-Goldberg Memorial Chapelinc 1170 Rockville Pike, Rockville, Maryland 20852 Signature of Funeral Service License Melissa Greenhut M01597 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Cerebrovascular Accident disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or iinjury Examine Due to (or as a consequence of) use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of). Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 \square Live Birth 2 \square Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed <u>Atrial Fibrillation</u> 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No æ 26. Place of Death (Check only one) Hospital Other: 1 Inpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injury 1 🗓 Natural 5 Pending Accident Investigation

Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and To the Funeral Director; After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-tran Division of Vital Records, P.O. Box 68760

Medical

4 Homicide

29a. Certifier

(Check

6 Could not be

determined

To the Hospital or within 24 hours a To the Funeral D

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 only one) Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) February 15, 2010 D65720 ne and address of person completed cause of death (Item 23a) (Type, I

😾 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

28f. Location (Street and Number or Rural Route Number,

MD 8600 *1*01/d Georgetown Road, Bethesda, Maryland 20817 Iwunze Rosemary 32. Registrar's Signature

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

State Registrar

			For State Registrar	State of N	Marylan		artmen <i>tificate</i>			and M	1ental Hy	gien Reg. N	2010	06760
	Physicia Medic		1. Decedent's Name (First, Middle, La. Jacky Lee	st)							2. Date of De Month Februar	ath	^{ay} 2010 ^{Year}	3. Time of Death 7:35 a M
	Examir		4a. Facility Name (if not institution, give				1	Kensi	Location on ngtan					gomery
	Funeral Director		110-24-0483	X M O T E	Age (In yrs. I 84	ast birthday) Yrs.	If Under Months	1 Year Days	If Under		8. Date of Bir March Da	th 1 <i>y,</i> 192 9	5 9. B	lirthplace (State or Foreign Country) hina
	ow at	-	Usual Residence of Decedent 10a. State 10b. County		10c Cit	y, Town or Lo	ration		-	-				10d. Inside City Limits
	Marylan 28a-f sh otified a	irecto		Montgomery	100.01		nsingt	on_						1 🔀 Yes 2 🗆 No
	with the 23a or 3	eral D	10e. Street and Number 10900 Orleans Way			-	10f. Zip	Code 2089	5			10g. C	itizen of What C USA	Country?
920	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 🌣 Widowed 4 ☐ Divorced	12. Was Deceden Armed Forces 1 Yes 2 [If Yes, Give Year or Dates	? □ No	1	Vas Deced f Yes, spec	ify Cuba	n, Mexican	gin? (Spe , Puerto l	cify Yes or No- Rican, etc.)		14. Race - Am Black, Wh Specify:	
Maryland 21215-0036	iin 72 hour ie. han "natur e Medical	omplete	15. Decedent's Elementary/Seconday (0-12)	ducation		16a. Deced (Give I life, De	kind of wor O NOT use	k done d	ation uring most	of workii	ng		Kind of Busines	
and 21	oe filed with ntal Hygier ted other t event, th	To Be C	17. Father's Name (First, Middle, Last) Unknown Lee			Che	<u> </u>				e (First, Middle, k La u	<u> </u>	Staurant Surname)	
Maryl	2 should be lith and Me 27 is mark traumatic	·	19a. Informant's Name/Relationship (7 Dolly A. Lee/Daugh	Type, Print) nter		19b Mailir 10900	a Address Orle	(Street a	nd Numbe ay, Ke	r or Rura nsing	I Route Number	2689	r Town, State, 2	Zip Code)
Baltimore,	age 1 and ent of Hea nt: If item ry or other		20a. Method of Disposition 1 A Burial 2 Cremation 3 4 Donation 5 Other (Speci		20b. F	Place of Dispo emetery, cren ge Wash	sition (Nam natory or o	ne of ther place Ceme	tery	Feb. 2010			ocation - City o	
Balti	permit. F Departm Importa any inju		21. Signature of Funeral Service Licens	·	70					Funer	al Home	Inc.	ng, MD 20	
	Physician/ Medical Examiner	r	23a. Part 1. Enter the disease, or comshock, or heart failure. List only climmediate Cause (Final disease or condition resulting in death) Sequentially list conditions.	plications that causine cause on each line cause on each line and a. Lung Cane Due to (or a	ne. cer		er the mode	e of dying	g, such as o	cardiac o	r respiratory ar	rest,		Approximate Interval Between Onset and Death Onset and Death
В	ate be executed hysician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Discase or impury that initiated events resulting in death) Last	Due to (or a										
. Box 68760	ath certifica attending p for use as t	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No g ☐ Unknown	23c. If yes, outcom 1 Live Birth 4 Pregnant 9 Unknown	2 Feta at time of c	al death 3 🗌	Ectopic p		/				23d. Date of d Month	elivery Day Year
s, P.O.	ires that the des signed by the d be detached to		Part II. Other significant conditions of	ontributing to death	but not res	ulting in the u	nderlying c	ause give	en in Part I.					to the cause of death?
Records,	The law require cate has been si page 2 should 1	Completed by										psy ormed?	prior to death?	autopsy findings available o completion of cause of
a F	ician; The certificate rector, pag	Be C	25. Was case referred to medical					26. Pla	ce of Deatl	h (Check		XX	101 1016	. Z LINO
Vit	ysician; nis certific director,	To B	examiner? 1 ☐ Yes 2 Ž No	Hospital:	itient 2 🗆	ER/Outpatien	t 3 🗆 DC	Othe	r:			dence	6 ☐ Other (Spe	ecify)
n of Vital	iding Phi th. After thi funeral		27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident Investigation	28a. Date of in (Month, D	jury	28b. Time of injury		Bc. Injury work?	at	2	28d. Describe h			ony
Division	tal or Attendii rs after death. al Director; Af ed in by the fu	al Certificate:	3 Suicide 6 Could not b	28e. Place of In building, e	etc. (Specify,	·) 					City or Tow	vn, State	p) 	ural Route Number,
	To the Hospital or within 24 hours after To the Funeral Dire	Medical	29a. Certifier (Check only one) 1 Certifying Physical Exam (Check only one) 3 Certifying Nurs	iner: On the basis of	examination	n and/or invest	igation, in n	ny opinio	n, death occ	curred at	the time, date a	and place	e, and due to the	cause(s) and manner stated.
	To the within 2 to the comple	5	29b. Signature and title of certifier				29c.	License	number			29d. Da	ate signed (Mon	th, Day, Year)
	SVA	7							D6223	4		Feb	oruary 16	, 2010
			30. Name and address of person who of Manish Agrawal, MD	9707 Med:				300, 1	Rockvi.	lle,	MD 20850			
	Stat Registra	e	31, Date filed (Month, Day, Year) FEB 19 2010	82. Regis	trar's Signat	bar	J.			-				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** RAYMOND 10 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anna Arundel Annapolis Anna Arundel County Medical Center 8. Date of Birth (Month, Day, Year) April 2, 1 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 1 → M 2 □ F 7. Age (In yrs. last birthday) **Funeral** Days Min 1942 Washington, DC 67 **Director** 579-54-1528 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the "Medical Evan in action in at the natified at once. 28a-f show 1 X Yes 2 □ No Director Anna Arundel Edgewater MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21037 144 Washington Road U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 06/1961

1 23Yes 2 \(\text{DNO} \) to If Yes, Give Year or Dates: 06/1964 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 □ Never Married 2 □ Married 1 ☐ Yes 2 🖾 No Specify: þ 3 ☐ Widowed 4 1 Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Laborer Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ardelia Annie Martin Richard Lee Morris ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Juanita_Yvonne Gaines/Sister 13459 Orangewood Drive, Woodbridge, VA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ₭ Burial 2 Cremation 3 Removal from State Lincoln Mem. Cemetery | 02/24/2010 Suitland, MD 4 Donation 5 Dother (Specify) Signature of Funeral Service Licensee 460208 22. Name and Address of Facility AMES FUNERAL HOME, INC. 8914 Quarry Road, Manassas, VA 20110 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final ERFORATED **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** 1965 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year 5 Other (specify) 1 □Yes 2 □ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? gnificant conditions contributing to death but not resulting in the underlying cause given in Part I. ş ncek mets 1 ☐ Yes 2 ☐ No 3 ☐ robably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 □ No 1 □Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Pinpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 1 Aatural 5 Pending death. 1 □ Yes 2 🗌 No investigation 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 **Z ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in mulasizing death. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29b. Signature and title of certifier eger. 3 person who completed cause of death (Item 23a) (Type, Print) RIEGER MD 31. Date filed (Month, Day, FEB 1

State Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Box 68760

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Division of Vital Records,

32. Registrar's Signature

Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day 2010 February Dusan L. Mihajlovich 5:30 AM 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Arden Courts Assisted Living Potomac Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Oct. 30, 1924 9. Birthplace (State or Foreign Country) Yugoslovia 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1**№** M 2□ F 169-26-2157 85 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c, City, Town or Location Maryland Montgomery Wheaton 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10800 Georgia Avenue Apt. 208 20902 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 K No If Yes, Give Year or Dates: Specify: Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Chief of Research Publishing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lazar M. Mihajlovich Hristosija M. Stajneller 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Theresa M. Butler / Attorney 11501 Georgia Avenue, Wheaton, MD 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Rock Creek Cemetery 2010 Washington, DC 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. hence 500 University Blvd., West, Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) BRAIN METASTATIC NEUPLAIN Due to (or as a consequence of): DEMENDA YRONS Sequentially list conditions Directo (unde a consequente ut) day, loading to immodia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Year Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?

Physician /Medical Examiner

be executed

Box 68760,

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Division of Vital Records,

Physician

Examiner

Funeral

Director

show

or items 23a or 28a-f shown items 23a or 28a-f shown items and items of the position of the state of the stat

ed other than "natural", or items event, the Wedical Examination

permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item any injury or other traumatic event, Ite Medical Eyroring. Once.

3altimore, Maryland 21215-0036

Director

Funeral

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/Medical

10a. State

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To the Hosp within 24 hou To the Funer completely fil

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sician and burial-transit attending physician for use as the buria spital or Attending Physious after death.
neral Director: After this y filled in by the funeral di Certification: To

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown

25. Was case referred to medical examiner?

1 Yes 2 No

27. Manner of Death

1 Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an

autopsy performed? Yes 2 No death? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 26. Place of Death (Check only one) ASSISTED

Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred

29c. License number

1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

COTTAGE CITY, MD 20722

5 Pending investigation

6 ☐ Could not be

determined

D-17874

29d. Date signed (Month, Day, Year) 2-17-2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3717 -

5-M. NAYAR 31. Date filed (Month, Day, Year)

FEB 19 2010

32. Registrar's Signature

State Registrar

Medical

Maryland 21215-0036

Baltimore,

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2010 N. Peter Makris 11:50 PM February Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery Shady Grove Adventist Hospital Rockville 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth **Funeral** (Month, Day, Year) 1918 Days 1 XM 2 □ F Months Hours Min. Country) 91 **Director** 578-46-0427 Greece ugust Usual Residence of Decedent 28a-f show 10a. State or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Montgomery Gaithersburg 1 Yes 2 X No. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 14058 Saddle River Drive 20878 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. <u>≽</u> 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify. White 3 Widowed 4 Divorced Specify: Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working filed within 72 all Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Food Service Restauranteur Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file h and Mental F 7 is marked of Nick Peter Makris Maria Lucas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health an Important: If item 27 is any injury or other trau 14058 Saddle River Drive, Gaithersburg, MD 20878 Fay Makris / Spouse Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Page 1 ament of I February 18, 2010 1 🕅 Burial 2 🗌 Cremation 3 🗌 Removal from State Parklawn Memorial Rockville, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility
DeVol Funeral Home, 10 East Deer Park Drive,
Gaithersburg, MD 20877 Signature of Funeral Service Lice se - Stule MO1117 1 RACY A 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Acute Leukemia disease or conditi-resulting in death) Chronic Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical certificate be 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 4 Pregnant 9 Unknown Pregnant at time of death 5 ☐ Other (specify) Month Day Year the signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law r within 24 hours after death. page 2 autopsy performed? Yes 2 X N 2 No 1 Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 **X** No ပ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) thours after death. uneral Director: After the ed filled in by the funeral 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending work 1 Yes 2 🗌 No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title 29d. Date signed (Month, Day, Year

Registrar DHMH 17 Rev 7/2009

State

Box 68760

P.O.

Records.

Division of Vital

M.1

2. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

John Michael Wallmark,

53177

9707 Medical Center Drive #300, Rockville, MD 20850

February 15, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ FEB.19, 2010 5:20 P M MENDENHALL KVETA Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death NATIONAL LUTHERAN HOME ROCKVILLE MONTGOMERY If Under 1 Year | If Under 24 Hrs. 8. Date of Birth NOV 17, 1914 ILLINOIS 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Min. 1 M 2 XF 95 340-03-2395 Director Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director MONTGOMERY MD. POTOMAC 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12828 HUNTSMAN WAY 20854 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ⚠ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. and Mental Hygiene. is marked other than "natural", or Completed by 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: WHITE Specify: 3 X Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) YRS HOMEMAKER AT HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Heath and Mental Important: If item 27 is marked c any injury or other traumatic eve once. ဂ KAREL MISKOVSKY ANNA KOUBA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KARL MENDENHALL-12828 HUNTSMAN WAY, POTOMAC, MD. 20854 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 K Cremation 3 ☐ Removal from State cemetery, crematory or other place)
METROPOLITAN CREM. 2/22/10 ALEXANDRIA, VA. 4 Donation 5 Other (Specify) 22. Name and Address of Facility 2222-WISCONSIN AVE., NW Signature of Funeral Service Live se HYSONG CO. WASHINGTON. 23a. Part 1. Enter the disease, or complications that outled the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final [™]Physician/ disease or condition Medical resulting in death) as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) attending physician and for use as the bunal-transit that the death certificate be executed that initiated events resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 1 No Month Veal Pregnant at time of death the 9 Unknown 9 Unknown ģ s been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Hospital or Attending Physician: The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed' certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medica completed filled in by the funeral director, 26. Place of Death (Check only one) examiner? Other: မ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 Matural 5 Pending s after death. 1 Yes 2 🗌 No 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. opty one) 29b. Signature 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHARLES W. KARESH -9701-VEIRS DR., ROCKVILLE, MD. 20850 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2 2 2010 Registrar

DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036

Box 68760

P.0.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death v 9,2010 **Physician** Kaye 8:05 aM Irvena February Majors /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Collington Episcopal Life Care Community Mitchellville Prince Georges If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2**X**□ F Wash. 68 DC Director 578-54-5552 02-11-1941 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show if than "natural", or items 23a or 28a-f sho Accokeek MD PG XX Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1503 St. Albans Ln. 20607 USA by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status 72 hours after 1 ∏Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2X No Specify: Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry oe filed wit. ⁺al Hygiene. **`er than "r** Elementary/Secondary (0-12) College (1-4or 5+) Pentagon Supply Technician permit. Pages 1 and 2 should be filed in Department of Health and Mental Hygin Important: If item 27 is marked other any Injury or other traumatic event, III. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Irving Jackson Ruth Ashton 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lisa M. Myers/ Daughter 1503 St. Albans Ln. Accokeek, MD 20607 Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Ft. Lincoln Cemetery 02-27-10 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Sonature of Juneral Service Licenses 22. Name and Address of FacilitRonald Taylor II FH 10583 Middleport Ln. White Plains, MD 20695 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a c sequence of): **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed and Due to (or as a consequence of) Box 68760. attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 📉 No signed by the a P.0. 9 Hlnknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ş 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has by page 2 s autopsy performed certificate 2X No Division of Vital 1 ∐Yes 2 🗷 No 1 ☐ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Assisting Other: 4 - Nursing Home 5 - Residence 6 - Other (Specify)Living 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Hospital or Attending spital to.
4 hours after dec.
--ral Director: Andre in by the for 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide n 24 hou. the Funeral Dire Medical 29a. Certifier 1🖰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho

To the Fune

completely f 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the

State Registrar

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29b. Signature and title of certifier

31 Date filed (Month, Day, Year)

Mercantile

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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DHMH 17 Rev 1/2001

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Largo

32. Registrar's Signature

29c. License number

D0059

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2010 Physician/ Feb. 15. 1340 P M Richard S. Nero, Sr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Holy Cross Hospital Silver Spring Montgomery 6. Sex 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Date of Driving (Month, Day, Year) 1926 **Funeral** 1 ፟ M 2 □ F Months Hours Min. Country) Mississippi Director 579-26-2740 83 May 6. Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 Yes 2 No Silver Spring Montgomery Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13705 Mills Avenue 20904 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. 1 Never Married 2 X Married þ 1 Yes Baltimore, Maryland 21215-0036 African 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed Year or Dates American 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) Computer Manager Private Be other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve ပ Richard Lee Nero Minnie Moore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gloria M. Nero/ Wife 13705 Mills Avenue Silver Spring, Maryland 20904 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)
Ft. Lincoln
Cemetery Burial 2 ☐ Cremation 3 ☐ Removal from State 'ebruaı Brentwood, Maryland ☐ Donation 5 ☐ Other (Specify) 2010 . Sig 22. Name and Address of Facility Stewart Funeral Home, Inc. 4001 Benning Rd. NE Washington, DC 23a. Part Chief the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition <u>Cerebrovascular Bleed Related To Hypertension</u> Medical resulting in death) Examiner Brain Death Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of, sician and burial-transit Cause (Disease or iinjury that initiated events The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Dav Year 5 Other (specify) 1 ☐ Yes ∠ ☐ 9 ☐ Unknown been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed?

Yes 2 1 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical æ 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital 1 ☐ Yes 2 🖾 No ည 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural injury 5 Pending 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Fractioner 1. The best of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Nejib Siraj, MD 1500 Forest Glen Road

32. Regis

D68150

Silver Spring, Md. 20910

February 17, 2010

			For State Registrar	State	of Marylan		artment of tificate of		and Mei	, ,	ne N2010	06768
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	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. la	ast birthday)	If Under 1 Yes			Date of Birth	9. Bi	rthplace (State or Foreign
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Baltimore,	permit. Page 1 Department of Important: If i any injury or once.	_	21. Signature of Funeral Service I		0.00					Funera		·
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P.O. Box 687	at the	윤	Part II. Other significant condition	one contributing to	death but not res	ulting in the u	nderlying cause	given in Par	+ 1	22a Did tabaar	an una contributa t	o the cause of death?
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Ö	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit											
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	,		30. Name and address of person									20010
			Dr. Nooshiv Par				len Roa	d, Sil	Lver Sp	ring, M	aryland 2	20910
	Stat	te	31. Date filed (Month, Day, Year)		Registrar's Signa	ture	41					

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ February 2010 Matthew 10:16 a^M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Lexington Park St. Mary's 19722 Teddy Way 5. Social Security Number 9. Birthplace (State or Foreign Country)
Maryland If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** Months Min. 1 🛣 M 2 🗆 F 0270471941 **Director** 69 217-38-2082 Usual Residence of Decedent th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 Yes 2XXNo Lexington Park Maryland St. Mary's 10g. Citizen of What Country? Funeral 19722 Teddy Way 20653 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: 3 Widowed 4 X Divorced Completed White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 11 Woodworking Master Craftsman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be file trment of Health and Mental rtant; If item 27 is marked o jury or other traumatic eve ပ္ Frank Pasik Agnes Scanlon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Lee/Daughter 19745 Three Notch Rd., Lexington Park, MD 20653 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important; If ite any injury or ot Date cemetery, crematory or other place) 1 ₭ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Trinity Episcopal 02/22/2010 St. Mary's City, MD 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 21. Signature of Funeral Service Licensee Kyle S. Simons MU1206 22955 Hollywood Rd., Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ph_sician/ Coronary Artery Disease disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Conjestive Heart Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): -transit Exam Hypertension requires that the death certificate be executed and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Panhypopituitarism Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed Chronic Kidney Disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law has autopsy performe certificate 2 🗌 No Yes 2 No 1 Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 🗌 Yes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) eral Director; After this filled in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending death. 2 Accident
3 Suicide 1 ☐ Yes 2 ☐ No Investigation 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined hours after To the Hospital within 24 hours a To the Funeral Completed filled in the Funeral Completed filled filled in the Funeral Completed filled Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Description of the cause 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 02/19/2010 D63150

State Registrar 30. Name and address of perso

31. Date filed (Month, Day, Year)

Narasimham Iswara, M.D.

22576 MacArthur Blvd., California, MD 20619

who completed cause of death (Item 23a) (Type, Print)

. Registrar's Signature

State

Registrar

Jason M. Prior, MD

FEB 19 2010

31. Date filed (Month, Day, Year)

32 Registrar's Signature

9901 Medical Center Drive, Rockville, MD 20850

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

	,	For State Registrar	State of M	/larylan		artment of rtificate o				gienę. Reg. No	7 11 1	0	06771
Physici: /Medic		Decedent's Name (First, Middle, Last SCOTT C	HARLES	RIDD	LE				2. Date of De Month Febru	Day		ear	3. Time of Death 1:00 p.M
Examin		4a. Facility Name (If not institution, give 53 Ash1ey Way	street and numbe	er)		4b. City, Town	ville]]	County of	ricl	
Funeral Director		5. Social Security Number 434-19-1153 Usual Residence of Decedent	x Дм 2□F	Age (In yrs. I	ast birthday) Yrs.	If Under 1 Yes		Min.	8. Date of Bir (Month, Da June 17	ay, Year)		Coun	ace (State or Foreign try) Siana
th the Maryland or 28a-f show	Director	10a. State 10b. County Maryland Frederi 10e. Street and Number	ck		, Town or Lo yersvi	lle 10f. Zip Cod		-		10g. Citiz	zen of Wh	at Coun	od. Inside City Limits 1 Yes 2 □ No try?
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the "Kedical Exarcinate the mostliked at once.	by Funeral Director	53 Ashley Way 11. Marital Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced	12. Was Deceder Armed Forces 1 XYes 2 If Yes, Give Year or Dates	S?]No 		Was Decedent of Yes, specify C	f Hispanic O uban, Mexica	in, Puerto	pecify Yes or No Rican, etc.))-	US 14. Race Black, Specify:	Americ White, e	tc.
ed within 72 hou ygiene. ier than "natura t, the "diest E	Completed	15. Decedent's Ed. (Specify only highest grad Elementary/Secondary (0-12) 1 2		r 5+)	(Give life.	dent's Usual Oc kind of work do DO NOT use ret outer Pi	ne during mo: red) ogramr	ner_		U.		over	nment
iould be file I Mental Hy narked oth	To Be	17. Father's Name (First, Middle, Last) Floyd Chauncey	Riddle		T		Cai	ro1		ısted	<u> </u>		
1 and 2 sh Health and em 27 is m		19a. Informant's Name/Relationship (7) Laci C. Riddle/wi 20a. Method of Disposition	,	20b. P	53 As	ng Address (Stresh 1 ey Wasition (Name of		ersvi		aryla		1773	
nit. Pages artment of ortant: If it injury or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify,		_ 00	Mark Mark	natory or other positions Luthe 2. Name and Ad	ran F	eb.10	0,2010	Wolf		le,	Maryland
Dep Imp any any		23a. Part 1. Inter the a recomp shock, rear ailure. List only o	10	ed the death		icketts er the mode of			ome My	ersvi			21773 Approximate Interval Between
Cate be executed which is care be executed which is care and the purial-transit the burial-transit in the buri	dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or a Due to .		ence of):	1.4	LTIF					-	S MONTHS
	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 ☐ Fetal tat time of d	death 3[☐ Ectopic pregna				2	23d. Date Mont		ory Day Year
w requires that the d s been signed by the should be detached	by	Part II. Other significant conditions co	ntributing to death	but not resu	Ilting in the u	nderlying cause	given in Part	I.	23e. Did			ute to th	e cause of death?
scian: The law red certificate has bee irector, page 2 shoo	Completed							_		psy ormed? 2 No	nri		psy findings available npletion of cause of 2 □ No
To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	ation: To Be	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 ☐ Inpa 28a. Date of Ir (Month, E		ER/Outpatier 28b. Time of Injury	f 28c. lr	ther:	lursing Ho	th (Check only of the control of the	idence 6	3 ☐ Other	, , ,	v)
ital or Atte	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	building,	etc. (Specify	·)	eet, factory, offic	<u>.</u>		City or To	wn, State,)		l Route Number,
o the Hosp rithin 24 hor o the Fune ompletely fi	Medical	29a. Certifier (Check only 2 Medical Examone) 29b. Signature and title of certifier	ner: On the hasis	of examinat	ion and/or in	vestigation in m	v oninion de	eath occur	rred at the time	date and	place an	d due to	the cause(s)
⊢ 5 ⊢ 0			MO CEN	f death (Item	23a) (Type.	Print)	.097	02:	5	02	108	3/2	1010
10 Sta	te ar	CLARE FERRIG 31. Date filed (Month, Day, Year)	NO 155	O ORL	EANS ·	29c. Lice R Print) ST, CR	3II,	1M-1	16, BA	10,	MD	2	1231

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar		State of Ma	aryiana /		irtment of F tificate of L		na Me		giene _{Reg. No.} 2	010	067	72
	Di di	/	1. Decedent's Name (Firs	st, Middle, Last)	_	,				2. Date of Dea	ath	1111	3. Time of De	eath
	Physicia Medic		Giles	Freder	ick :	Shilli	ngber	g]	Februa:	cy 28	201 ^{Year}	18:161	РМ
	Examin		4a. Facility Name (if not in		treet and number)			4b. City, Town, or	Location of	Death			ounty of Death		
4			610 Bentle					Hagers				Was	hingto	n	
	Funeral	V	5. Social Security Number	1 1	x 7. Age XX 12 □ F	(In yrs. last b		If Under 1 Year Months Days	If Under 24 Hours	4 Hrs. Min.	8. Date of Birt (Month, Da	h y, Year)	9. Birtl	hplace (State or Fo	oreign
	Director		213-24-8637 Usual Residence of Dece			80	Yrs.			A	Aug. 20	1929	Virg	inia	
	show at	or		c. County		10c. City, To	wn or Loc	ation						10d. Inside City L	_imits
	faryls Ba-f : tiffied	Director	MD V	Washingt	-on	Напа	rsto	T.773						1 🗆 Yes 2	X No
	or 2	õ	10e. Street and Number		2011	nage	Taro	10f. Zip Code	-			10g. Citizer	n of What Cou	untry?	
	with \$23a ust b	eral	610 Bentle	ey Court	:			21740				J	U.S.A	-	
	leath Items er m	Funeral	11. Marital Status		12. Was Decedent E Armed Forces?	ver in U.S.	13. W	as Decedent of Hi	spanic Origin	n? (Speci	fy Yes or No-	14.	Race - Amer		
36	ifter of ", or amin	by	1 Never Married		1 XXYes 2 X	√ o		Yes 2 No		rue to ni	can, etc.)		Black, White		
8	ours a tural	Completed	3 Widowed 4 D	Divorced Decedent's Ed	Year or Dates.							Spe	ecify: Whi	te	
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ğ	iled v Il Hyg I othe vent,	Be	17. Father's Name (First,								First, Middle,	Maiden Suri	name)		
<u>la</u>	d be f Aenta arked arked	욘	Samuel J.	Shillir	ngberg				Eliz	a El	len Bo	oth			
lan,	shoulk and N is ma		19a. Informant's Name/F			19	9b. Mailin	g Address (Street a	and Number	or Rural I	Route Numbe	r, City or Tov	vn, State, Zip	Code)	
≥	and 2 sealth m 27		Janet V. Sh	nillingt	erg/Wife		610	Bentley (Court,	Hage	rstown	, MD	21740		
ore	ye 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hyglene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	3	20a. Method of Disposition 1 ☐ Burial 2 🎇 Cr		Removal from State			sition (Name of atory or other plac	e)	Da	ite	20c. Locat	tion - City or T	Town, State	
Ξ̈́	Page 1 tment of tant: If it jury or o		4 Donation 5			Smith		g Cremat					hsburg		
Baltimore, Maryland 21215-0036	permit. Page 1 Department of Important: If it any injury or o		21. Signature of Funeral	Service License	e			Name and Addres					eral C		
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١.			23a. Part 1. Enter the dis shock, or heart failu Immediate Cause (Final	ure. List only on	e cause on each line	the death. Do	not enter	r the mode of dying	g, such as ca	ardiac or i	respiratory an	est,		Approximate Interval Between Inset and Dea	
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	Examiner		,		Due to (or as a	consequence	∋ of):								
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387			IF FEMALE:		0.16							1			$\neg \neg$
×	ath certifica attending p for use as t	ian,	23b. Was decedent pregr in the past 12 month	hs?	3c. If yes, outcome of 1 ☐ Live Birth 2 4 ☐ Pregnant at	2 🗀 Fetal dea		Ectopic pregnanc	у			23d	. Date of deliver Month	very Day Year	
ă	the a	Physician/N	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		9 Unknown	time of death	5 🗀	Other (specify)					WOTEN	Day Tour	
Division of Vital Records, P.O. Box 68	hat thed by	y P	Part II. Other significant	t conditions cor	ntributing to death bu	ıt not resulting	g in the un	derlying cause giv	en in Part I.		23e. Did to	bacco use	contribute to	the cause of death	h?
ڻ ک	Jires 1 1 sign 11d be	Completed by									1 🗹	/es 2 □ 1	No 3 🗆 Pro	obably 4 🗌 Unk	nown
000	w req	olete									24a, Was a	an 2	4b. Were auto	opsy findings avai	lable
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<u>a</u>	ian: T rtifica xtor, p	BeC	25. Was case referred to	medical	* .			26. Pla	ace of Death	(Check o	1 🗌 Yes	2 L3 No	1 ☐ Yes	2 LJ 1NO	
₹	nysic nis ce I direc	일	examiner? 1 Yes 2 No	, H	ospital: 1 Inpatie	nt 2 🗆 ER/0	- Outpatient	3 🗆 DOA Othe	r: 4 🗆 Nurs	sing Home	e 5 Resid	ence 6 🗆	Other (Specif	ý)	
ō	ng PI fter th		27. Manner of Death 1 Natural 5	☐ Pending	28a. Date of injury (Month, Day,	y 28b. Year)	Time of injury	28c. Injury work	at	28	d. Describe h	ow injury oc	curred		
<u>o</u>	tendi leath. :or: A the fu	iţice	2 Accident	Investigation Could not be				M 1 □	Yes 2 □ N	10					
N N	or At after o Direct in by	Certificate:	4 Homicide	determined	28e. Place of Injur building, etc.		farm, stree	et, factory, office		28	If. Location (S City or Tow		imber or Rura	al Route Number,	
Ω	To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours affect eath. within 24 hours affect eath. To the Funeral Director, Affer this certificate has been signed by the attending completed filled in by the funeral director, page 2 should be detached for use as		29a. Certifier 1	Partifulna Dhur-	cian: To the best of r	ny knowda de -	death	coursed at the time	date and -1	200 25	duo to th	100(a) -: '	anna	o d	
	e Hos 24 h e Fun leted	Medical	(Check 2 \bigsqcup N	∕ledical Examin	cian: To the best of r er: On the basis of ex Practioner: To the b	amination and	or investig	gation, in my opinio	n, death occu	urred at th	ie time, date ai	nd place, and	d due to the ca	ause(s) and manne	r stated.
	Vithir To the comp		29b. Signature and title o		. raviolier, to the E	SE OF THE KILO	wieuge, ut	29c. License		nu piace,			gned (Month,		
			>6 Mich	wel 1.	Mulom	11	no	04	166)			. 2 . 1		
			30. Name and address of		mpleted cause of de	ath (Item 23a)	(Type, Pr	int)							
			Miche		Clorne	ele	111	10 Me	lical	(impos	10	ajen	han A	10
	Stat Registra	٠ .	31. Date filed (Month, Day	y, Year) MAR U 5	32. Registrar	's Signature	S.	Bortos							

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Deeth 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** 10 Smith Paul /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Allegany Frostburg Frostburg Village Nursing Home Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Dec 7, 7. Age (In yrs. last birthday) 5. Social Security Number Min. **Funeral** Months Days Hours 1 🙀 M 2 🗆 F MD 83 723-09-1186 Director Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 Is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10a. State ral", or items 23a or 28a-f shov Examirer must be notified at 1 ☐ Yes 2 ☐ No Frostburg MD Allegany Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21532 USA Frostburg Village Nursing Home Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 Pyes 2 □ No If Yes, Give Year or Dates: Korean 1 Never Married 2 Married 1 Yes 2 No Specify Baltimore, Maryland 21215-0036 Specify. white ρ Korean 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natureny injury or other traumetic event, the Medical eny injury or other traumetic event, the Medical 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Schmidt Bakery laborer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Nellie Hess Smith William J.B. Smith ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) PΑ 17015 Carlisle 26 Brian Drive niece Janice Mooney 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 3/1/2010 MD Rocky Gap Veterans Cemetery Flintstone 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Scarpelli Funeral Home, PA 21. Signature of Funeral Service Licensee 108 Virginia Avenue: Cumberland, MD 21502 23a. Perf. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metastatic **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d Date of delivery signed by the attendin I be detached for use 23b. Was decedent pregnant 3 Fctopic pregnancy Month Day Year in the past 12 months?
1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2.27No 2 🗆 No 1 ☐ Yes 26. Place of Death (Check only one) funeral director, Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death To the Hospital or Attending 5 Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No after death. 2 Accident completely filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 Suicide determined 4 Homicide e Funeral L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[In Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 026907

DHMH 17 Rev 1/2001

State

HARJIT SIT

31. Date filed (Month, Day,

WAISH ROAD CLUMPERLAND, MD 21502

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5

32. Registrar's Ignature

DHU

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
AMEND ITEM#5perFH, G932, 10/18/2012, WS
State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Carleen Loeffler Sims FEBRUARY 16 2010 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 9707 Old Georgetown Road #3A Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 1 □ M 2 F 415 44 2843 578-62-0332 98 11/18/1911 Washington, DC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Montgomery Bethesda 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 9707 Old Georgetown Road #3A 20814 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 Z No If Yes, Give Year or Dates: 1 Never Married 2 Marned 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 AWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, Carl August Loeffler Minnie Schneider 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Martin / Daughter 5604 Wood Way Betherds, No. 20816 ce of Disposition (Name of Date 200. L 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Arlington Nat. Cemet. 03/29/2010 14 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Arlington, VA 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Joseph Gawler's Sons Inc. 5130 Wisconsin Ave. NW Washington, DC 20016 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part1. Enter the disease Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Respiratory Failure Due to (or as a consequence of): Pneumonia Sequentially list conditions, if any, Learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner physicien and s the burial-transit or Attending Physicien: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760. the 60 signed by the attending the detached for use as should should certificate After thi funeral

Physician

/Medical

Examiner

Funeral

Director

28a-f show

5

, or Items 23a

"natural"

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if Item 27 is marked other than 'any injury or other traumatic event, tra Magnie.

MD

Directo

Funeral

þ

Completed

Examine

Completed by Physician/Medical

Be

2

Medical Certification:

The Medical Examiner must be notified at

with the Maryland

filed within 72 hours after death

Baltimore, Maryland 21215-0036

23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 9 Unknown Peripheral Vascular Disease Coronary Artery Disease

1 ☐ Yes 2X No 27. Manner of Death 1 X Natural 2 Accident

3 Suicide

29a. Certifier

5 Pending investigation 6 ☐ Could not be determined 4 Homicide

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Cartifying Physician: To the best of my knowledge, death occurred at the time, date and due to the cause(s) and manner stated.

| Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number D35791 mu

29d. Date signed (Month. Day, Year) 02/18/2010

Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a (Type, Print)

Merlyn K. Vemury MD 9801 Georgia Ave. Bethesda, MD 20816 31. Date filed (Month Day, Year) FEB 19 2010 ∴ Registrar's Signature

State Registrar

Jaspiter L 4 hours after dea. 1 real Director: After

To the Hospitel Within 24 hours

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day Ye ar 2/25 **Physician** 2010 JAMES KENNETH SHELTON /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's Upper Marlboro 13627 Water Fowl Way If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min Months 1⊠M 2□ F Director 04/28/1962 578**-**96-3231 Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a. State ral", or items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 Z No by Funeral Director Upper Marlboro Prince George's MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20774 permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Ill important: If item 27 is marked other than "natural", or items 23a any Injury or other traumatic event, Ite Itemical Ferrica once. 13627 Water Fowl Way 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No 14. Race - American Indian, Black, White, etc. X Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Prince George's Elementary/Secondary (0-12) College (1-4or 5+) County Police Dept. Police Officer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Eva Arthur ၉ Melvin Henry Shelton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 10303 Fleming Avenue, Bethesda, MD 20814 Cynthia Shelton - sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lingolh Park Cem. 2/20/10 Rockville, MD 21. Sign of Funeral Service Live 22. Name and Address of Facility Snowden Funeral Home 246 N. Washington St, Rockville, MD 20850 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Physician ArTerroset eretic /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) P.O. Box 68760, physician the burial attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 3 - Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ₫ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown s been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas page 2 autopsy performed certificate 1 ☐Yes 2 No 26. Place of Death (Check only one) director. 25. Was case referred to medical Be Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 Yes 2 □ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) funeral 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After Injury 1 Natural 5 Pending 1 □Yes 2 □No investigation neral Director: , filled in by the f 2 Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar SALVAGOS 31. Date filed (Month, Day, Year) FEB 19

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February 14 Peggy C. Schwartzbeck 7:48 P M 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 K Months Days Hours (Month, Day, Ye July 16, 1935 West Virginia Director 235-52-0415 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits with the Maryland "natural", or items 23a or 28a-f sho edical Examiner must be notified at Director Maryland Montgomery Derwood 1 Ves 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 16816 Bethayers Road 20855 United States within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🗵 No Specify Specify: Completed 3 Widowed 4 Divorced White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) f Health and Mental Hygiene. item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Fred Cook Beatrice Burks other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul Schwartzbeck (Spouse) 16816 Bethayers Road, Derwood, Maryland 20855 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Feb. Date 8 permit. Page 1 s
Department of H
Important: If ite
any injury or ot cemetery, crematory or other place)
Gate of Heaven
Cemetery 1 🖾 Burial 2 🗌 Cremation 3 🔲 Removal from State 4 Donation 5 Other (Specify) Silver Spring, MD 2010 DeVol Funeral Home, 22. Name and Address of Facility 10 E. Deer Park Drive, Gaithersburg, MD 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition **Encephalopathy** Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examin EX resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 0 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Year Day Pregnant at time of death Unknown 9 Unknown 7 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? B þ Cardiomyopathy, Pulmonary Hypertension, 1 ☐ Yes 2 😾 No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an Peripheral Vascular Disease autopsy performed? death? 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 2 💢 No Other: 1 Tyes ည 1 X Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 1 ื Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined To the Hospital continuity within 24 hours af To the Funeral Discompleted filled in Completed filled in The ART The Total Completed The Total Comp Medical 29a. Certifier X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) Z 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year, D60117 February 15, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Park, M.D., 9901 Medical Center Drive, Rockville, MD 20850

State Registrar 31. Date filed (Month, Day, Y

Year.

Registrar's Signal

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Artin February Di77, Nerses Sabounji 9:00 a 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Rockville Hospital Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Country) Syria **Funeral** 1**X** M 2 □ F Months Days Hours 217-72-4428 April Day4 Year) 1931 78 Director Usual Residence of Decedent fshow 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f Maryland Montgomery 1 Yes 2 X No Derwood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Examiner must be 23a Funeral 7733 Rydal Terrace 20855 USA within 72 hours after death Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No þ 1 Never Married 2 Married Maryland 21215-0036 White If Yes, Give Year or Dates. 1 ☐ Yes 2 No 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the Autobody Technician Automotive Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ould be file ould be file outside ၉ Nerses Sabounji Yeran Nakashian Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7733 Rydal Terrace, Derwood, MD 20855 Zabel Sabounji/Wife Page 1 and 2 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Feb 2010, 20c. Location - City or Town, State **X** Burial 2 ☐ Cremation 3 ☐ Removal from State All Souls Cemetery 4 Donation 5 Other (Specify) Germantown, Maryland Signature of Funeral Service Licenses Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused to see beath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ Cardiopulmonary Arrest Medical resulting in death) Due to (or as a consequence of) Examiner Liver Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Exami inding physician and use as the burial-transit Renal Failure Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physicis Hypotension Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year Pregnant at time of death Unknown 5 Other (specify) Yes 2 No 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death? 1 Yes 2 No ☐ Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 2 1 No Other: Certificate: To 1 🗌 Yes NX Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1x Natural 5 Pending injury work? 2 D No M Accident Investigation filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined building, etc. (Specify) Medical 29a. Certifier 🛚 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 0 D67512 February 17, 2010 and address of person who completed cause of death (Item 23a) (Type, Print)

dan Bangalore, MD 9900 Medical Center Drive, Rockville, MD 20850 30. Name and address of person who allore, Madan Bangalore,

State Registrar 31. Date filed (Month,

1 9 2010

Registrar

OCME 2006

State

WIJL

8

29b. Signature and title of certifie

Zabiullah Ali, M.D.

EB

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

32. Registrar's Signature

29c. License number

O.C.M.E

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

DCME

February 18, 2010

			For L State Registrar	State of Ma	aryland	•	artment of F			lental Hy	/giene Reg. No	001	Ω	05	770
	Physicia	an	1. Decedent's Name (First, Middle, Las	,						2. Date of De Month	eath Da	y Ye.		3. Time (
	/Medic	al	4a. Facility Name (If not institution, giv	Lloyd Smit			4b. City, Town, or	Location	n of Death	Februa		4, 20	_	4:30	a "
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I	Funeral Director		5. Social Security Number 6. S 216–34–6619	ex 7. Ag	je (<i>In yrs. l</i> as 72	t birthday) Yrs.	If Under 1 Year Months Days	If Unde Hours	er 24 Hrs. Min.	8. Date of Bi (Month, D	rth la <i>y, Year)</i> , 193		Counti	^{ace (State} ry) Land	e or Foreign
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation						10	d. Inside	City Limits
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	or 28a	Jirec	10e. Street and Number				10f. Zip Code				10g. Cit	izen of What		ry?	
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020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, I've Modeal Evan The Total by Total and once.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:		j	Was Decedent of H f Yes, specify Cuba 1 □Yes 2X No	ispanic C an, Mexic Specii		ecity Yes or N Rican, etc.)	0-	14. Race - A Black, W Specify: \(\cup\)	hite, et	tc.	
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	Page tment tant: If jury or		1 ☐ Burial 2 🗖 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Removal from State y)	Ca	rroll	Cremato:	ry	2/18	/2010	iW	infiel	1, E	1D	
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,00	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as	•	9		AB. 2							
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0.00	ne death cer the attendin	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal de	eath 3	Ectopic pregnanc Other (specify)	у				23d. Date of Month		ry Day	Year
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)	MZL Solution	M	29b. Signature and title of certifier			/	29c. Licens		r 43		29d. Da	ate signed (M	onth, E)ay, Year)	
	3		2	DDIQI		6212	Print) SYKESVILL		40,	5ykesu.	LLE,	AD.	برابد الم	84	
	Sta Registr		31. Date filed (Month, Day, Year) FEB 18	2010 Elen	rar's Signatur	B. 1	bak								
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			For State	State of Marylar				Mental Hy	giene		
			Registrar		Cer	tificate of E	Death		Reg. No.2	10	06780
	Physicia	n/	1. Decedent's Name (First, Middle, L					2. Date of Dea	Day	Year	3. Time of Death
	Medic Examin		Leon Wayne 4a. Facility Name (if not institution, gi			4b City Town or	Location of Death	Februa	ry 18, 2		7:10 a ^M
	LAGITIII	CI	St. Mary's Nur			Leonar				. Mar	v's
T	Funeral			Sex 7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day	h		place (State or Foreign
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	nd show at	or	Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Lo	cation		<u> </u>		1	0d. Inside City Limits
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	the N a or 2 be no	اقا	10e. Street and Number	Idly 5		10f. Zip Code			10g. Citizen of V	What Coun	try?
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	r iten iner r	/ Fu	11. Marital Status1 ☐ Never Married 2 X Married	12. Was Decedent Ever in U. Armed Forces?	.S. 13. V	Was Decedent of Hi f Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		e - America ck, White, e	
920	s after ral", o Exam	d by	3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 □ No If Yes, Give Year or Dates.	1	I ☐ Yes 2 🔀 No	Specify:		Specify:	. Wh	nite
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Baltimore, Maryland 21215-0036	be file antal F ked o c eve	10	Leon Fred	Smith			18. Mother's Nam Esther		maiden Surname .npeter	3)	
ar _Z	should be filed within 72 hours after death with the Maryland hand Mential Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship		19b. Mailir	ng Address (Street a				State, Zip C	Code)
Σ	e 1 and 2 should be of Health and Menti fitem 27 is marked r other traumatic e		Mary E. Smith/S	pouse	1	35 Ann La			-		·
ore	of He of He If iten		20a. Method of Disposition 1 Burial 2 Cremation 3		Place of Dispo cemetery, cren	sition (Name of natory or other plac	e)	Date	20c. Location -	City or To	wn, State
Ē	Pag tment tant: jury c		4 Donation 5 Other (Spe			ld-Echols			Charlot		
Ba	permit. Page 1 Department of Important: If it any injury or o		21. Sig Funeral Service Lice Edward N. Brins	field, Jr. MOO		Name and Address 22955 Hol					
			23a. Part 1. Enter the disease, or co shock, or heart failure. List only	mplications that caused the dea		er the mode of dying	g, such as cardiac	or respiratory arr	rest,		Approximate Interval Between
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_	death certificate be executed re attending physician and ed for use as the burial-transit	dical E	resulting in death) Last	Due to (or as a consec	quence of):						
3760	ficate g phys	/ledi		a .							
× 687	n certifi endine	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregn	ancy tal death 3	Ectopic pregnanc	:v		23d. Da	ite of delive	ery
Вох	requires that the death certific been signed by the attending I should be detached for use as	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at time of 9 ☐ Unknown		Other (specify)			Мо	onth	Day Year
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<u>></u>	Phys r this ral dir	<u>۲</u>	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 Inpatient 2 28a. Date of injury	ER/Outpatier 28b. Time of	it 3 🗆 DOA	4 Mursing H		lence 6 Othe		
o nc	nding ath. r. Afte e fune	icate	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident Investigat	(Month, Day, Year)	injury	work		Zod. Describe in	ow injury occurr	Ju	
Division of Vital Records,	To the Hospital or Attending Physiciam: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	Certificate:	3 Suicide 6 Could not 4 Homicide determine	be 280 Place of Injury At h		eet, factory, office		28f. Location (S City or Tow	treet and Numbern, State)	er or Rural	Route Number,
	Hospital 4 hours Funeral ted fillec	Medical	29a. Certifier 1 Certifying Ph (Check 2 Medical Exa	nysician: To the best of my know miner: On the basis of examination	vledge, death o	occured at the time,	date and place, and notice and place, and notice and place.	nd due to the cau	use(s) and manne	er as state	d. use(s) and manner stated.
	To the within 2 To the comple	Ĭ	only one) 3 Cortifying My	urea Practioner: To the best of m	ny knowlodgo o	looth occurred at the	atimo data and ala	as and due to the	and me	annor ac ota	ntod
	as .		· m	attendin	3	00	05568	2	2/	19/1	O
	Ley.		Su. Name and address of person who	completed cause of death (Iter	10 27	7130 M	oalcley	St Lei	mardt	TOWA	Mo 20650
	Stat Registra	te ar	29b. Signature and tiple of certifier 30. Name and address of person who 31. Date filed (Month, Day, Year)	32. Fegistrar's Signa	A. A.	ake	•				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 4:26 a M 2010 February Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death St. Mary's Mechanicsville 38843 Hidden Pond Court Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 05/22/1957 **Director** 52 Washington 214-68-8961 Usual Residence of Decedent 10a. State 10c. City. Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland ms 23a or 28a-f sho must be notified at 10d. Inside City Limits Director 1 Yes 2 No Maryland St. Mary's Mechanicsville 10e. Street and Number 10g. Citizen of What Country? Funeral 20659 38843 Hidden Pond Court USA items ; 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. P þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Yes, Give 1 ☐ Yes 2X No Specify: "natural" 3 Widowed 4 Divorced Completed White Year or Dates. Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) if Health and Mental Hygiene. item 27 is marked other than other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 12 Railroad Mechanic Railroad Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ Scholten Robert Frances Lugenbee1 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 38843 Hidden Pond Ct., Mechanicsville, MD 20659 Deborah M. Scholten/Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot
once. 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Charles Memorial 02/26/2010 Leonardtown, MD 4 ☐ Donation 5 ☐ Other (Specify) Sign as o pul Serve consee

Euwaru N. Brinsfield, Jr. M00052 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 22955 Hollywood Rd., Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Ph_sician/ Chronic Obstructive Lung Disease disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter ordenying Examine Due to (or as a consequence of) burial-transi Cause (Disease or iinjury that initiated events and Due to (or as a consequence of): resulting in death) Last physician s the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ___ in the past 12 months? Day 2 No cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Insulin Dependent Diabetes Mellitus 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of Hypertension 24a, Was an performed? Yes 2 2 No death? certificate 1 Yes 2 No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) 2 2410 Hospital: 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🗷 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred After (Month, Day, Year) 1 Natural 5 Pending injury nours after death.

neral Director: Aft
filled in by the fur 1 Yes 2 No M 2 Accident
3 Suicide
4 Homicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, determined building, etc. (Specify) within 24 hours at To the Funeral D Completed filled in Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) the of certifie 10 29b. Signature and titl 29c. License number Q D 21031 66 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Waldorf, MD. Michael Leatherwood, M.D. 31. Date filed (Month, Par.) gistrar's Signature State 2 5 201

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 2010 1:30 a.m. Physician/ February Smith Shirley Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** St. Mary's Lexington Park 20489 Renaissance Court g. Birthplace (State or Foreign Country) New Jersey 8. Date of Birth If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number Days Day, Year) Hours **Funeral** Months 1 M 2 X F Yrs 69 Director 149-30-5675 Usual Residence of Decede 10d. Inside City Limits 10c. City, Town or Location permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at. or 28a-f show 10b County 10a, State 1 🗌 Yes 2 ី No Director Lexington Park Maryland St. Mary's 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe United States Funeral 20653 20489 Renaissance Court 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. 1 Never Married 2 X Married 1 ☐ Yes 2 🖾 No Specify: ò Specify: Baltimore, Maryland 21215-0036 White 3 🗌 Widowed 4 🗆 Divorced Completed 16b. Kind of Business Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Nursing Registered Nurse 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) Estelle Louise Strigh 2 John Milton Smith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20489 Renaissance Ct., Lexington Park, MD Edwin J. Smith/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition Brinsfield-Echols Cre 02/27/2010 | Charlotte Hall, MD 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 21. Signature of Funeral Service Licensee 2955 Hollywood Road, Leonardtown, MD Kyle S. M01206 Simons 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a cor **Examiner** Samuentially list conditions. Due to (or as a consequence o): Examine if any, leading to immediate cause. Enter Underlying or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events and the burial-tran Due to (or as a consequence of): resulting in death) Last signed by the attending physician d be detached for use as the burial Physician/Medical P.O. Box 68760 IF FEMALE 23d Date of delivery yes, outcome of pregnancy 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 - Fetal death Year Month Day in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tyes Records, 24b. Were autopsy findings available prior to completion of cause of death?
 1 □ Yes 2 □ No 24a Was an autopsy performed? Yes 2 N has , page this certificate 26. Place of Death (Check only one) 25. Was case referred to medical Division of Vital Be the funeral director, Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 2 X No 1 Yes မ 28d. Describe how injury occurred 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 27. Manner of Death Certificate: work? 1 Yes 2 No thin 24 hours after death. 1 Natural 2 Accident 5 Pending M Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Could not be Suicide within 24 hours after dear To the Funeral Director completed filled in by the 4 Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Hospital Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) the

ORMO State

Tot

6 Registrar

Schmidt,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D.0

32

29b. Signature and title of certifier

Jennifer

Registrar's Signatur

29c. License number

40900 Merchants Lane, Suite 205, Leonardtown, MD

DHMH 17 Rev 7/2009

Registrar

FEB 22

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month EBRUARY Day Year 14 2010 АМ DORIS 9.36 SWEENEY Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 X F July 22, Year 935 219-46-3694 Mary land 74 Director Usual Residence of Decedent or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits event, the Medical Examiner must be notified at Director Maryland Frederick 1 Tes 2 X No Thurmont 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 23a 8142 Apples Church Road 21788 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces? 1 ☐ Yes 2 ☐ No Black, White, etc. ō 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 🛮 Widowed 4 🗆 Divorced If Yes, Give Specify: White Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. onday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last 18. Mother's Name (First, Middle, Maiden Surname) ပ္ permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Bruce Paul Delauter Evelyn M. Stockman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diana Tregoning / Daughter 9245 Waynesboro Pike, Emmitsburg, Maryland 21727 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Resthaven Mem. Garden's 2/18/2010 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 615 EAST MAIN STREET, THURMONT, MARYLAND 21788 21. Signature of Funeral Service 23a. Part 1. Enter the d sease, or condicate that cause the d shock, or heart failure. 18. only one cause chily e. o not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final MONAM Cmbalism Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exami for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical P.O. Box 68760 . If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year signed by the at d be detached for 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 2 🗌 No 2 A No 1 Yes Yes within 24 hours after death.

To the Funeral Director: After this certific: completed filled in by the funeral director, I 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 Inpatient 2 X ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Gentifying Nume Fractioner To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 20035152 2-15-10 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 100 KRINA evTer S 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death FEB. 15, 2010 Physician/ P^{M} 9:45 THERON SNYDER Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner MONTGOMERY ROCKVILLE NATIONAL LUTHERAN HOME If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** MAR 12, Yea 1 DXM 2 □ F Months Days Hours Min. PENNSYLVANIA 190-12-1557 84 1925 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b County 10a. State Director "natural", or items 23a or 28a-f si dical Examiner must be notified MONTGOMERY ROCKVILLE 1 Yes 2 □ No MD. 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? Funeral 20850 USA 9537 VEIRS DRIVE #3 Page 1 and 2 should be filed within 72 hours after deathment of Health and Mental Hygiene. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 X Married 1 ☐ Yes If Yes, Give þ Specify:WHITE Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: 3 Widowed 4 Divorced Completed Year or Dates other than "natu 16b. Kind of Business Industry 15 Decedent's Education 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) CLERGYMAN RELIGION Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) LOTTIE ARENTZ ပ SNYDER is marked R. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Department of Health ar Important: If item 27 is any injury or other trau ROCKVILLE, MD. 20850 9537 VEIRS DRIVE #3 BETTY W. SNYDER 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
METROPOLITAN CREM. 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 2/16/2010 ALEXANDRIA, VA. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 22 – WISCONSIN AVE., NW Signature of Funeral Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of ach 10. HYSONG WASHINGTON DC 20007 Approximate Interval Between Onset and Death Immediate Cause (Final Ph, sician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying the Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transi Cause (Disease of hinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) Month Year in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Tes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be Hospital: Other: 2 ₩No 1 🔲 Yes 4 Sursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) eral Director: After thi filled in by the funeral 28b. Time of 28c. Injury at 27. Manner of Death 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check and title of certifier 29c. License number 29b. Signature 1726 vary 18,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20850 VEIRS DR., ROCKVILLE, MD. KARESH-9701-CHARLES W. 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 7/2009

Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 13, FEBRUARY 2010 9:28P LILLIE MAE TOLLER /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGE'S MANOR CARE LARGO If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 □ F Months Days Hours Min 84 Director 228-26-3073 28 1925 VIRGINIA Usual Residence of Decedent 10d. Inside City Limits 10a, State 10c. City, Town or Location 28a-f shov 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Evanting must be notified at Director MD PRINCE GEORGE'S LANHAM 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a USA 20706 4807 WHITFIELD CHAPEL Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 □ Yes 2 □XNo Specify: Specify: BLACK þ 3√ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 72 (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOUSE KEEPER PRIVATE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 should be fi Be RUSSELL WOODRUFF MATILDA ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:3 Department of Health a Important; If item 27 is any Injury or other trac JENKINS/GRANDDAUGHTER 3311 BROOKSHIRE COURT UPPER MARLBORO, MARYLAND 20772 TANYA 20c. Location - City or Town, State 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) Date 1 □ Burial 2 □ Cremation 3 □ Removal from State 2/20/2010 DAVIDSONVILLE, MARYLAND 4 Donation 5 Dother (Specify) LAKEMONT CEMETERY 21. Signature of Funeral Service Licensee J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician ACUTE RESPIRATORY FAILURE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner CARDIAC ARRHYTHMIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed HYPOXEMIA the burial-tran Due to (or as a consequence of): Box 68760, physician Physician/Medical CARDIAC FAILURE use as attending IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy ō in the past 12 months? Month Day Year 5 Other (specify) 1 ∐Yes 2 🕅 No o the detached 9 ☐ Unknown ģ σ. signed t Ibe deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 ▼ No 24a Was an certificate 1 □Yes 2√ No the Hospital or Attending Physician: director 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1∐Yes 2∑No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To funeral c 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 🖸 Natural 5 Pending in 24 hours after control the Funeral Director: After the funeral by the funeral 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) To the I 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier MD 52855 FEBRUARY 16 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7207 HANOVER PARKWAY #B GREENBELT, MARYLAND 20770 rı D , 32. Registrar's Signature CHANDRASEKHAR KORAPATI 31. Date filed (Month, Day, Year) State Registrar 1. 1

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	Otato or ivi	ar y larra /	•	tificate of L		mornari	Reg.	No.		
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	Examin		4a. Facility Name (if not institution, Potamac Valley Nu	-	ss Cente	r	4b. City, Town, or Rockvi 11		ith		4c. County of	Death	7
	Funeral Director		5. Social Security Number 178–14–0682	6. Sex 1 ☐ M 2 ☐ F 7. A9	e (In yrs. last b 88	oirthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		Birth Day Year 1921	ur) E		ace (State or Foreign Živania
	yland -f show ed at	ctor	Usual Residence of Decedent 10a. State 10b. County		10c. City, To		ation			-		10	0d. Inside City Limits
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	h with th ns 23a o nust be	Funeral Director	2 Tapiola Court				10f. Zip Code 20850				Citizen of Wh	at Count	ry?
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, Mary	of and 2 should be of Health and Menta fitem 27 is marked rother traumatic e		19a. Informant's Name/Relationsi Frances A. Brownel		1	9b. Mailin 1100 S	g Address (Street a	and Number or F Nurt, Unit	Pural Route Nui 5, Pomp	nber, City ano B	or Town, Sta leach, Fl	te, Zip C 330	ode) 50
imore	Page 1 arment of He tant: If iten		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		ceme	tery, crem	sition (Name of eatory or other place In Cemeters	re) Feb	310 ^{Date}	- 1	:. Location - C	-	
Balt	permit. Page Department of Important: If any injury or		21. Signature of Funeral Service L	icensee	_	22	Name and Address 500 Univers	odiniys E sity Blvd.	Tuneral H W., Sil	iome I ver S	nc. pring, l	MD 20	901
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	with con-		29b. Signature and title of certifier	endl	lug	2001	29c. License	e number 8262			Date signed (
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Baltimore,	permit. Page Department. Important: If any injury or		21. Signature of Funeral Service Conference 22. Name and Address of Facility Harkins Funeral Home, Inc., Delta, PA													
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 14, 2010 Physician Ellen E. White February 7:25 p ^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** St. Catherine's Nursing Center Frederick Emmitsburg 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday **Funeral** 8. Date of Birth (Month, Day, Year) Months Days Hours Min 1 □ M 2 1 F 116-16-0053 85 Director New York Apr 14, 1924 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
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Department of IImportant: If ite
any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/16/2010 Winfield, MD Carroll Crematory 22. Name and Address of Facility 21. Signature of Funeral Service License Myers-Durboraw Funeral Home 210 W Main St. Emmitsburg, MD 21727 23a. Part 1 Enter the disease, or complications If at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 41 disease or condition resulting in death) /Medical ue to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within £4 hours later death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 mont 1 ☐ Yes 2 No Month Day Year 5 Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ≥ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 □ Yes 2 No 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only on 1∐Yes 2XX No Hospital: Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 🔲 No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

— Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stat 29b. Signature and title of certifi

WJL 3

Registrar DHMH 17 Rev 1/2001

State

SETON

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ARROLI

FEB 18

31. Date filed (Month, Day, Year)

310

32. Resistrar's Signature

South

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death Day Lillian Elizabeth Month Williams 5:49PM February 4b. City, Town, or Location of Death 4c. County of Death Lexington Park St. Mary's 46860 Hilton Drive, Apt 2814 If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, 9. Birthplace (State or Foreign 1 □ M 2 🖾 F Days Months 84 Yrs. April 26. New Jersey 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Tes 2 No Lexington Park St. Mary's 10f. Zip Code 10g. Citizen of What Country? 46860 Hilton Drive, Apt 2814 20653 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 Married Yes 2 X No 1 ☐ Yes 2 🖾 No Specify Specify: Black If Yes, Give 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+)

1. Decedent's Name (First, Middle, Last) Physician/ Medical 4a. Facility Name (if not institution, give street and number) Examiner Social Security Number **Funeral** Director 098-20-5344 Usual Residence of Deceden 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at L 1215-0036

Learnit. Page 1 and 2 should be flied within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural" any injury or other traumatic exercises any injury or other traumatic exercises. 10a. State Directo Maryland 10e. Street and Number Funeral 11. Marital Status þ Completed 12 Licensed Practical Nurse Private Duty Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Daisy Johnson Robert Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lila Williams-Brown / Daughter 1785 Story Avenue, Apt 14H , Bronx, New York 10473 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State February 22 4 Donation 5 Other (Specify) 2010 Alexandria, Virginia Signature of Funeral Service License 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270 Leonardtown, MD 20650 23a. Part 1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician en disease or condition resulting in death) Month Medical Due to (or as a consequence of) Examiner ysthen months Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Conresh P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death detached sate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? eral Director: After this certificate filled in by the funeral director, pag 2 X No 1 Tes 2 No Yes the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death
1 Natural
2 Accident 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending injury death. 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide after determined City or Town, State) thin 24 hours a the Funeral C Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2

To the comple only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) D0061719 2010 TRMI and add s of person who completed cause of death (Item 23a) (Type, Print) 24035 Three Notch Road Hollywood, MD 20636 Dhananjay Bhavsar, M.D. 31. Date filed (Month, Day, Year) 32. Redistrar's Signature State

DHMH 17 Rev 7/2009

Registrar

FEB 22

10-01422 Stephen Webster

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0-01422 tephen Webste		State of Maryland / Department of F -For State State of Maryland / Department of E	lealth and Mental	l Hygiene			
Physicia		Registrar 1. Decedent's Name (First, Middle,Last)		2. Date of Death		3. Time of Death	
cal Exami		Stephen Glen Webster		Month February 1		0155 hrs	
		,	City, Town, or Location of Di Elkton	eath	4c. County of Death Cecil		
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 177 62 5635 1 1 2 F 28 Yrs.	If Under 1 Year If Under 24 Months Days Hours	4Hrs. 8. Date of Birth Min. 12/16	(MM/DD/YYYY) 9. Birth West 1981 pg	nplace (State or Bt Chester Intry) USA	
	E	Usual Residence of Decedent				10d. Inside City Limits	
w any		10a. State 10b. County 10c. City, Town or Location PA Chester Oxford	1			1 X Yes 2 No	
Maryland 28a-f show any d at once.	흱		10f. Zip Code	10	g. Citizen of What Coun	try?	
r death with the Maryland or items 23a or 28a-f sho must be notified at once.	Director	740 Broad St.	19363		USA		
with the 18 23a			Decedent of Hispanic Origin? , specify Cuban, Mexican, Pu	? (Specify Yes or No-	14. Race - Americ White, etc.	can Indian, Black,	
death or iten	Funeral	1 X Never Married 2 Married 1 Yes 2X No		gerto Ricari, etc./	Specify: Bla	e c k	
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72 hours after death with the Maryland n "natural", or items 23a or 28a-f she al Examiner must be notified at once	ğ	Elementary/Secondary (0-12) College (1-4 or 5+)	t of working life. DO NOT use	e retired)		-	
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15-0036 filed within 72 hours after I Hygiene. ed other than "natural", o t, the Medical Examiner 1		17. Father's Name (First, Middle, Last) H. Timothy Gray		Name (First, Middle, Michelle We			
212 hould be nd Menta is marko atic even	To Be	19a Informant's Name/Relationship (Type Print) 19b Mailing A	Address (Street and Number Broad St. (or Rural Route Num	per, City or Town, State,	Zip Code)	
ages I and 2 should not of Health and Mar. If item 27 is not other traumatic	-	20a Method of Disposition 20b. Place of Disposition	on (Name of cemetery,	Date	20c. Location - City or	Town, State	
Baltimore, MI permit. Pages I and 2 s Department of Health a Important: If item 27 injury or other traum		1 Burial 2 Cremation 3 Removal from State crematory or othe Oxford	rplace) Cemetery	2/27/10	Oxford,	PA 19363	
Iltim nit. Pa artmen ortani	H	4 Denotion E Other Specify:	me and Address of Facility	Edward L	. Collins	Funeral	
Ba Pern Dep Imp		Hor	ne, Inc. 86	Pine St	. Oxford,	PA 19363	
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the failure. List only one cause on each line.	mode of dying, such as card	tiac or respiratory arre	st, shock, or heart	Approximate Interval Between Onset and Death	
/Medical Examiner		Immediate Cause (Final disease or condition resulting in death) A Multiple Injuries Due to (or as a consequence of):				Death	
		Sequentially list conditions, b					
	aminer	frany, leading to immediate cause. Enter Underlying Cause					
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OX 68760, and certificate be executed attending physician and or use as the burial - transit	al Ex	d					
O, be ex	edic	UNPENDED			23d. Date of delivery	,	
Box 68760 e death certificate be the attending physied for use as the bu	sician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Feta	I death 3 Ectopic pr	regnancy		Day Year	
OX 6: eath cert	Sicia		er (Specify)				
the de ched f	된	Part II. Other significant conditions contributing to death but not resulting in the un	derlying cause given in Part I	1. 23e. Did to	bacco use contribute to	the cause of death?	
cords, P.O. law requires that the has been signed by 2 should be detach	d by			1 Yes	es 2 No 3 Probably 4 Unknown		
rds, require been should	Completed			24a. Was a autop	sy prior to o	topsy findings available completion of cause of	
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of Vital Recing Physician: The After this certificate uneral director, page	ပ	1 Yes 2 No Inpatient 2 ER/Outpatient			Residence 6 Other	r: Scene	
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Divisior To the Hospital or Attend within 24 hours after death. To the Funeral Director: completely filled in by the	Certification:	3 Suicide 6 Could not be determined (Specify) Major Road / Highway	, factory, office building, etc.	or Town S	Street and Number or Rutate) vay & Melbourne Bou		
Di To the Hospital within 24 hours To the Funeral		e, and due to the caus	e(s) and manner as stat	ed.			
To the within To the comple	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation and manner stated	29c. License number	ared at the time, date	29d. Date signed (Mo		
	Σ	29b. Signature and title of certifier	O.C.M.E.		February 17, 20		
2		30. Name and address of person who completed cause of death (Item 23a)					
~	tate	Ling Li, MD Assistant Medical Examiner 111 Penn Street 31. Date filed (Month, Day, Year) 32. Registrar's Signature	, Baltimore, MD 2120	1			
Regis		EED a glood of the desired					

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ORIGINAL

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 2010 03:58 AM MARTHA KATHARINA WRIGHT EB /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner General Hospital Columbia Howard County 5. Social Security Number Howard Birthplace (State or Foreign Country) 8. Date of Birth Month, Day, Yea 4/29/1936 6 Sex 7. Age (In vrs. last birthday) **Funeral** 1 M 2 H F Months Davs Hours Min. 212-40-3568 Director Germany Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location Department of Health and Mental Hygiene. Important: If item 22a or 28a-f show important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If the Medical Examinat must be notified at 1 Tyes 2 No. Director Ellicott City MD Howard 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21042 United States 2926 Woodwick Ct. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 No 14 Bace - American Indian. 11. Marital Status 1 ☐ Yes 221 If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 Xio Specify: þ Specify: 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) Salesperson Retail 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anna Reindl ဂ Johann Kapperer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michele A. Wright - Daughter 2926 Woodwick Ct. Ellicott City, MD 21042 20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Hanover, MD 4 ☐ Donation 5 ☐ Other (Specify) Cremation 2/20/10 22. Name and Address of Facility Harry H. Witzke's Family F.H. Inc 21. Signature of Funeral Service Licensee 4112 Old Columbia Pike Ellicott City, MD 21043 M01044 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) SEPTIC SHOCK /Medical Due to (or as a consequence of): Examiner BOWEL ISCHEMIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner URINARY TRACT Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗆 No 1 □ Ýes 1 TYes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 ☐ Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

be executed burial-trar Box 68760, physician law requires that the death certificate the attending pl P.O. detached ģ signed t Records, cate has to certificate Division of Vital this funeral After t the Hospital or Attending האסקיים. ה 24 hours after death. he Funeral Director: Af

Maryland 21215-0036

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d 2 should be filed wi th and Mental Hygier 7 is marked other th

Pages 1 and 2

Baltimore,

6 ☐ Could not be determined

FEB 22

🗠 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature and title of certifier

4 Homicide

(Check only

29a. Certifier

Medical

29c. License number

29d. Date signed (Month, Day, Year)

DO067127

FEB. 19, 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Luciano Amado 31. Date filed (Month, Day, Year, State

Howard County General Hospital Cedar Lane Columbia, MD 21044 32. Registrar's Signature

Registrar

npletely

within 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Year Virginia D. Woodfield February 2010 14, 7:30A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4803 Park Avenue Bethesda Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours 1 M 2X F 92 Director 578-32-3993 13, 1918 Jan. West Virginia Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show Director 1 NYes 2 No Maryland Montgomery Bethesda 10e. Street and Number 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with or items 23a or 4803 Park Avenue 20816 Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 【XNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 other traumatic event, the Medical Exarcit 1 □Yes 2 🛛 No If Yes, Give Year or Dates: è Specify Specify: White 3 XWidowed 4 ☐ Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 12 Own Home Department of Health and Mental Hygis Important: If item 27 is marked other i any injury or other traumatic event, II 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas Allen DeMoss Osceola ဂ္ဂ Mays 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jon N. Woodf<u>ield</u> - Son 4803 Park Avenue, Bethesda, Maryland 20816 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 2/26/2010 5 ☐ Other (Specify) Salem Meth. Cemetery Germantown, Maryland 21. Signature of Funeral Service licensee 22. Name and Address of Facility Home 20872 Molesworth-Williams P.A., Funeral Ho 26401 Ridge Road, Damascus, Maryland Vevert 0 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physicia<u>n</u> disease or condition resulting in death) Con a trice /Medical Due to (or as a con aquence of): Examiner AS HO Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): that the death certificate be executed Exami and physician ar s the burial-t Due to (or as a consequence of) Box 68760 Physician/Medical as 1 for use a IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) P.0. signed by the a ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, \$ 1 ☐ Yes 2 ☐ No 3 Probably Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No autopsy performed? certificate | Division of Vital 2 No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 **⊅≪**es 2 □ No Other: 4 \(\text{Nursing Home} \) 1 Nursing Home 5 Residence 6 \(\text{Other} \) Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 5 Pending investigation death. 1 Tyes 2 Accident hin 24 hours after death the Funeral Director: the. 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ۵ determined 4 Homicide filled in the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) within To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar D 29018

2101 Medical Park Drive - #304, Silver Spring, Maryland

February 16, 2010

20902

DMS

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Betsy Ballard, M.D.

31. Date filed (Month.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death February Physician/ 2830PM Goldie A. Williams 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Doctor's Hospital Prince George's Lanham 8. Date of Birth (Month, Day, Ye Dec 18, Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Country) V<u>irginia</u> 1 □ M 2 🖾 F Months Days **Director** 88 Dec. 579-34-6422 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f sho Director 1 X Yes 2 No Upper Marlboro Maryland Prince George's 10f. Zip Code 10q. Citizen of What Country? Funeral 12809 Staton Court United States 20774 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12, Was Decedent Ever in U.S 14. Race - American Indian 11. Marital Status Armed Force Black White etc. African 1 Never Married 2 Married Completed by 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify: American If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify 3 X Widowed 4 Divorced the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 8th <u>Private</u> Department of Health and Mental Hygi Important; If item 27 is marked other any injury or other traumatic event, I 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Arthur Porter Rhetta Henderson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 sh ment of Health a **ant; If item 27 is** 439 Peabody Street, NW Mary A. Duarte/ Daughter Washington, DC 20011 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Ft. Lincoln Brentwood, Maryland permit, A mature of Fun and Service Line 22. Name and Address of Facility Stewart Funeral Home, 20019 Washington, DC 4001 Benning Rd. NE Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Instromestinu disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events 4nemi burial-tran Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical b Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.
Parental Director: After this certificate has been signed by the attending physicis Division of Vital Records, P.O. Box 68760 as the IF FEMALE nse yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? cate has been signed by the atte page 2 should be detached for Month Day Year Pregnant at time of death 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed 1 Yes 2 No Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific: completed filled in by the funeral director, I 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 2 No 1 🗌 Yes 1 SInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 잂 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: 1 Natural (Month, Day, Year) 5 Pending Investigation ☐ Accident 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature title of certifie 29d. Date signed (Month, Day, Year) MDD 60925 Elizabeth FASIKA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8118 Good Luckled. zabeth MDe tasi Ka 31. Date files (Month, Day, Year) FEB 2 2 2010 State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Wendy March 5:14 AM 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** The Johns Hopkins Hospital **Baltimore City** Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 07-29-71 If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number . Age (In vrs. last birthday) **Funeral** 1 M 2 X Months Days Hours 38 BO Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10h County 10a, State 10c. City, Town or Location 1 Yes 2 No or 28a-f sh notified a Director BO NA Smith 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? pe 49 Town Hill Road FL07 Bermuda Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education the Medical (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Insurance Co. 12th Grade Administrative Asst. 2vrs. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Millard Alfred Bean Merlyn Adele Allen item 27 is marke other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 49 Town Hill Road Merlyn A. Allen-Mother Smith, Bermuda FL07 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any injury or ot X1X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Christ Church Cem 03-13-10 Devonshire, BO 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Wylie Funeral Home P.A. Street Baltimore, Gilmor 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician MUXOID malianant Spindle disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infiniediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of, the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy Month in the past 12 months? Day Pregnant at time of death 5 Other (specify) 2 W NO 9 Unknown 9 I I Inknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 1 ☐ Yes 2 No Other: 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) ၉ this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: To the Hospital or Attending P within 24 hours after death.

To the Funeral Director: After t 1 Natural 5 Pending investigation 1 🗌 Yes 2 🗌 No 2 Accident filled in by the Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, Cify or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Cerlifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified D68482 March 05 2010

State Registrar

31. Date filed (Month, Day, Year)

30. Name and address of person who con-

32. Registrar's Signature

ged cause of death (Item 23a) (Type, Print)

MAR DR 2010

JELA

Dense B. Sparks

600 North Wolfe St, Baltimore, MD, 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. / 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Year 02:28 A M 2010 MARCH Christopher Cornelius Aherne Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death ST. JOSEPH MEDICAL CENTER TOWSON BALTIMORE Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday 8. Date of Birth **Funeral** (Month, Day, Year) 2/23/1947 1**X**M 2 □ F Days Min. Director 217-50-6004 Usual Residence of Decedent 10b. County 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 28a-f 1 Yes 2 XNo Maryland Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must be Funeral Shawnee Court 21234 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 XNo If Yes, Give Maryland 21215-0036 1 ☐ Yes 🏋 No Specify. Specify: White 3 ☑ Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Apartment Complex Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Aherne (Unknown) Honorah 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cynthia Lynn Harrison (Daughter <u>23574 North FM219</u> Stephenville, Texas 76401 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith Cem Overlea, Maryland . Signature of Funeral Service Licenses 22. Name and Address of Facility Bruzdzinski Funeral Home 1407 Old Fastern Avenue PA Fssex, Maryland 21221 23a. Part 1. Enter the disease, or plicative that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IOCARDIAL INFARCTION Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical (or as a consequence of Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Cause (Disease or iinjury Hospital or Attending Physician; The law requires that the death certificate be executed burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician I for use as the buria Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day Year 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? certificate Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 1 Inpatient ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 1 Natural 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending injury 1 🗌 Yes 2 No Investigation 6 Could not be To the Funeral Director: A completed filled in by the f Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 46356 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar KHOSROW

TABA551

32. Registrar's Signature

7601 OSLER DRIVE

TOWSON

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day 2010 ear MARCH Evelyn C. Briean 5:10p Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Carroll Hospital Center Westminster Carroll Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, 8. Date of Birth **Funeral** 1 □ M 2 □ F Days Hours Min. Maryland Director 217-18-5854 86 923 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10b. County 10d. Inside City Limits Director Maryland Carroll Sykesville 1 Yes 2 No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 851 Margo Court 21784 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. þ 1 Never Married 2 M Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes Give White Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Typist Coast Guard 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Agnes C. Thomas Richard J. Loeschke 19a. Informant's Name/Relationship (Type, Print)
William A. Briean, Jr./husband 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) 851 Margo Court Sykesville, MD 21784 20b. Place of Disposition (Name of cemetery, crematory or other place)
Lorraine Park Cemetery 20c. Location - City or Town, State 1 🏋 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 3/6/2010 Baltimore, MD 21. Signature of Funeral Service Licenses Haight Funeral Home & Chapel, P.O. Box 195 Sykesville, MD P.A. 21784 Dauge Jaight Herbert (410-795-1400) 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final a Hysician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner cromomino Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown Pregnant at time of death 5 Other (specify) Month Day Year signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed been si 24b. Were autopsy findings available prior to completion of cause of 24a. Was an s certificate has be lirector, page 2 s autopsy performed' death? 2 1 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 Yes 2 🗹 No Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1_ Natural 5 Pending 2 🗆 No 2 Accident
3 Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) Maran 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Werkneiter MO 4152 Stones

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

MAR 0 8 2010

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 2010 /Medical 4து Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Commons Birthplace (State or Foreign Date of Birth (Month, Day, 7. Age (In yrs. last birthday) Funeral Social Security Number 6. Sex Months 1 □ M 2 🛂 Hours Min. Yrs. Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be mainted. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2120 S.A Funeral be 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 tbj 1 ☐Yes 2 📉 No Specify Specify: Black 3. Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Med 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rutal Route Number, City or Town, State, Zip Code) Datto Kona 21201 20a. Method of Disposition

1 M Burial 2 Cremation 3 R
4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 3 ☐ Removal from State 3-10-2010 Name and Address of 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) nysician asemer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed Physician/Medical Exami the burial-tra Due to (or as a consequence of): Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. s been signe should be a Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed of Vital 1 □ Yes 2 No 1 □ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 5 Residence 6 Other (Specify) 2000 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Division 1 Natural 2 ☐ Accident 5 ☐ Pending investigation death. 1 ☐ Yes 2 No after death 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide the Hospital within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 047683 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tay more Mille nut Mrc Registrar's Signat State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Benjamin 0. Bowden OORM 2010 nond /Medical 4a. Facility Name (If not institution, give street and number) Town, or Location of Death 4c. County of Death 4b. Citv. Examiner Daltimara locy land 1057.Ta 500000 If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Date of Birth Birthplace (State or Foreign Country) Funeral 236-44-4299 **1**X□ M 2□ F Months Days Hours Min. 09/26/1927 82 WV **Director** Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If or Modical Exyminer must be notified an once. 1 Xyes 2 No Director MD Baltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2095 Rock Rose Avenue 21211 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 12 Yes 2 □ No If Yes, Give Year or Dates: E.T.a 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. ð Specify: White 3 ☐ Widowed 4 Divorced Era Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Heavy Equipment Operator Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Oaklan Samuel Bowden Josie Audrey Griffith ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Collins, Daughter 411 Cypress Street, Millington, MD 21651 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Kent Cremation Services 03/06/2010 Smyrna, Delaware 4 ☐ Donation 5 ☐ Other (Specify) T. Harman rvice Licensee 22. Name and Address of Facility Trader Funeral Home 1250 12 Lotus Street, Dover, DE 19901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** HUSPINGTON railura disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner torise Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): 27515 sician and burial-tran Due to (or as a consequence of): P.O. Box 68760 attending physician for use as the buria Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery signed by the atte 3 Ectopic pregnancy in the past 12 months? Day Yea Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗙 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) completely filled in by the funeral 27. Manner of Death 28b. Time of After 1 28d. Describe how injury occurred 28c. Injury at Work? To the Hospital or Attending within 24 hours after death. To the Funeral Director: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Robina Rama. MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 641 11 C 100 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 08 2010

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** Elsie Ruth Cornes 11:00 2010 March p /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Ivy Hall Geriatric Center Middle River Baltimore Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Sex 7. Age (In vrs. last birthday) **Funeral** Months 1 □ M 2 1 € F March 10,1924 Maryland Director 214-24-5274 Usual Residence of Decedent within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State a or 28a-f show be notified at 10b. County 1 Yes 2 No Directo MD Howard Ellicott City 10f. Zip Code 10g. Citizen of What Country? U.S.A. 8909 Old Frederick Road 21043 "natural", or items 23a dical Examiner must b by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Heath and Mental Hygien Important: If item 27 is marked other this any injury or other traumatic event, the any injury or other traumatic event, the 12 Homemaker own Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lawrence William Cornes Mary Elizabeth Dollenger ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cindy Mae Cornes Roth /Daughter 8909 Old Frederick Rd Ellicott City, MD 21043 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Final Journey Crematory 3/8/2010 4 ☐ Donation 5 ☐ Other (Specify) Woodbine, MD 21. Signature of Euneral Service Licens Dorota Marshall 22. Name and Address of Facility Maryland Cremation Services P.O. Box 1413 Baltimore, MD 21203 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ŧ Immediate Cause (Final 3 lucs **Physician** disease or condition resulting in death) /Medical Due to (or as a confequence of): Examiner TOV Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last and burial-trai Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Completed by Physician/Medical as the attending IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Month 4⊡Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No detached the 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Uniknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death?
1 ☐ Yes 2/ NO 1□ Yes 2□N6 To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? (Month, Day Year) Injury 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide * Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ASTERN BLUD - M.D-21221. SASEBM 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 3/6/2010 Physician/ 8:00 PM Edna Roberta Carter Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Transitions Health Care Sykesville Carrol1 **Funeral** Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. Months Days Hours Min, 8. Date of Birth Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 🗆 M 2 🎛 F Month 7 1924 Director 217-12-5210 86 MD Usual Residence of Decedent show Page 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 No MT) Baltimore Baltimore 10e. Street and Number 10g. Citizen of What Country? Funeral 2842 Ridge Rd. 21244 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Completed by 1 Never Married 2 Married ☐ Yes 2 🔀 No Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify. "natural", 3 X Widowed 4 ☐ Divorced White Year or Dates permit. Page 1 and 2 shoust constitution of Health and Mental Hygiene.
Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical.] 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) 6 Washed Hair Beauty Salon Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Harry Paulus Genieve O'Neal 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roberta Whetzel 2842 Ridge Rd., Baltimore, MD 21244 Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State lake View Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) 3/11/2010 Sykesville, MD Signature of Funeral Service Licenses 22. Burrier Queen Funeral Home & Crematory, P.A. 1212 W. Old Liberty Rd., Winfield, MD23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death herosclerone Cardovascular Immediate Cause (Final Physician/ Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): ate has been signed by the attending physician and page 2 should be detached for use as the burial-transi the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of). resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) 1 Yes 2-14 9 Unknown Yes 2 No g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 2 ☐ No 3 ☐ Probably 4 🗷 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner?
1 Yes Other: Nursing Home 5 Residence 6 Other (Specify) 2500 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural work? 1 ☐ Yes 2 ☐ No 5 Pending ☐ Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Gertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 29b. Signature and title of certific

State Registrar idue Road

30. Name and address of person who completed cause of death (Item 23a) (Type

31. Date filed (Month, Day, Year)

MAR 08 2010

MAKMUUD

Funeral Director Baltimore, Maryland 21215-0036

Physicia /Medic Examin

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division or Vital Records, P.O. Box 68760,

Regis

	1 - State Registrar	C	ertificate	of Death		F	Reg. No.			
į.	1. Decedent's Name (First, Middle, Last) Albert Charles Cook 2. Date of Death Month Day Year Albert Charles Cook									
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er	4a. Facility Name (If not institution, give street and number	-)		4b. City, Town, or Location of Death Ruxton				4c. County of Death Baltimore		
	Manor Care-Ruxton 5. Social Security Namber 6. Sex 7. A	ige (In yrs. last birthda	ay) If Under 1	Year If Under		8. Date of Birth	n .	9. Birthpl	ace (State or Foreign	
	414-20 -8155- 17 M 2 G F	87 Yrs	Months	Days Hours	Min.	Aug 22,	1922	Penns	sylvania	
	Usual Residence of Decedent							11	Od. Inside City Limits	
1	10a. State 10b. County Baltimore	10c. City, Town or	SON					1	1 □Yes 2XXNo	
ecto		10%		Codo			10g. Citizen o	What Coun	try?	
To Be Completed by Funeral Director	10e. Street and Number 212 Aigburth Road		10f. Zip (21286			U.S		,.	
era	12. Was Deceder	nt Ever in U.S. 1	3. Was Decede	ent of Hispanic O	rigin? (Sp	ecify Yes or No-		ace - Americ		
표	1 ☐ Never Married 2 ☐ Married Armed Forces 1 ☐ Yes 2 ☐ If Yes, Give		1 ☐ Yes 2	fy Cuban, Mexica		nicari, etc.)	Spec			
by	3 ☐ Widowed 4 ☐ Divorced Year or Dates								White	
etec	15. Decedent's Education (Specify only highest grade completed)	16a. De	ecedent's Usual live kind of work DO NOT use	l Occupation k done during mo e retired)	st of work	ing	16b. Kind of	Business/inc	dustry	
du	Elementary/Secondary (0-12) College (1-40	r5+) }	Salesmar				Sa	les		
ပို	17. Father's Name (First, Middle, Last)			18. Moti		e (First, Middle,				
OB	Corydon Rodley C	ook		M	arie		Ah	rens		
	19a. Informant's Name/Relationship (Type. Print)			(Street and Num					Code)	
	Stephen Cook-son			ey Rd.,		er Sprii			Otata	
	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Sta	20b. Place of Di cemetery,					20c. Location	-	Jwn, State	
	Burial 2 Decremation 3 Removal from State Hilltop Serv Corp 3/8/2010 Towson, MD									
	23a. Part1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each	sed the death. Do not							Approximate Interval Between	
	Immediate Cause (Final disease or condition	ite R	espira	ntory	Fa	iluva	2	1	Onset and Death	
	regulting in death)	as a consequence of)	V	J						
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iner	Sequentially list conditions, in arry, leading to immediate cause. Enter Underlying Cause (Disease or injury	as a consequence of,								
хаш	that initiated events c	as a consequence of)	*							
Medical Examiner	d									
edic							1			
N/W	IF FEMALE: 23c. If yes, outcome 1 □ I ive hirth	me pf pregnancy	3 □Ectopic pro	eanancv				Date of deliv Month	ery Day Year	
sicia	in the past 12 months? 4 □ Pregnan	t at time of death	5 ☐ Other (sp					WOTHT	Day You	
Physician/	9 ☐ Unknown Part II. Other significant conditions contributing to deat		ne underlying o	ause given in Par	t I.	23e. Did	tobacco use c	ontribute to t	the cause of death?	
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eted	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	the				24a. Was	san 24	b. Were aut	opsy findings available	
Completed by	Cardiomyopa					auto	psy ormed?	prior to co death?	ompletion of cause of	
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To Be	examiner? 1 Yes 2 No Hospital: 1 Inp	atient 2 ☐ ER/Outp	atient 3 DC	Other		lome 5□Res		Other (Speci	ify)	
n:T	27. Manner of Dea h 28a. Date of (Month.	Injury 28b. Tir Day Year) Inj	ne of 2	8c. Injury at Work?		28d. Describe	how injury oc	curred		
atio	1 Natural 5 □ Pending (Month, investigation		М	1 ☐ Yes 2	□No	- LOEN			· ·	
I iji	3 Suicide 6 Could not be determined 28e. Place of building	injury - At home, fam , etc. <i>(Specify)</i>	n, street, factory	y, office		28f. Location City or To	(Street and Nu own, State)	ımber or Rui	al Route Number,	
Ce	29a. Certifier 1 Certifying Physician: To the b	est of my knowledge,	death occurred	at the time, date	and place	e, and due to the	e cause(s) and	I manner as	stated.	
Medical Certification:	(Chack only one) 2 Medical Examiner: On the bas and manne	is of examination and	or investigation	n, in my opinion,	death occi	urred at the time	e, date and pla	ce, and due	to the cause(s)	
Me	29b. Signature and title of certifier	*		c. License numbe			29d. Date sig	gned (Month	, Day, Year)	
	Michael Atter	iding	\square \square	0059	183	3	Mar	ch, C	14, 2010	
	30. Name and address of person who completed cause	of death (Item 23a) (T 3 4 15 6 e gistrae's Signature	ype, Print) Uora (Lane #	216,	TOWS	on N	10 216	204	
ate	31. Date filed (Month, Day, Year) 32. Reg	gistraris Signature	2				()			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death PATRICIA E. DAGES Physician/ MARCH 0250AM 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death HARBOR N/A HOSPITA1 BALTIMORE Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign . Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 □ M 2 🗷 F (Month, Day, November Country)
Maryland Months Days Hours Min. Director 217<u>-34-8748</u> 71 Usual Residence of Decedent or 28a-f show should be filed within to ...
I am d Mental Hygiene.
I is marked other than "natural", or items 23a or 28a-1 showning event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🗷 No Anne Arundel Brooklyn Park Maryland 10e. Street and Number 10g. Citizen of What Country? Funeral 113 East Audrey Avenue 21225 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?
1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 Specify: White 1 Yes 2 No Specify If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Proof Operator Wachovia Bank Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Melvin F. Smith M. Gallion Marv permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Julia Ann Stewart (Daughter) 113 East Audrey Avenue, Brooklyn Park, Maryland 21225 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery March 6, 2010 Brooklyn Park, Maryland 22. Name and Address of Facility McCully—Polyniak Funeral Home P.A. 237 East Patapsco Avenue, Baltimore, Maryland 21225 . Signature of Funeral Service Licenses Park. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ CERVICAL CANCER WITH LUNG METASTASIS disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to tor as a consequence on that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death 5 Other (specify) Month Day Year the signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy e Hospital or Attending Physician: The Is 24 hours after death.
9 Funeral Director: After this certificate heleted filled in by the funeral director, page performed? Yes 2 N 2 No 1 Tes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ဂ္ Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie RESO01 MARCH, 3, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 HANOVER STREET, BALTIMORE, MARYLAND

State Registrar

Box 68760

Records, P.O.

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MONO ANDREW Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CARROLL HOSPITAL CENTER ARROLL WESTMINSTER If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1**X** M 2 □ F Director Usual Residence of Decedent or items 23a or 28a-f shov 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event. 10c. City. Town or Location Completed by Funeral Director 10d, Inside City Limits 1 Yes 2 No CARROLL SYKESVILLE 10g, Citizen of What Country? 2178 3735 1514 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian. 1 Never Married 2 Married 1 Yes Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced WHITE Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) CONSTRUCTION To Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) LEMAR BRIAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROAD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) WINFICLD, MD 16/2010 22. Name and Address of Facility J NZUMBRUN FH & MUNGO Signature of Funeral Service License GOIT SYKESVILLE RID ELDERSBURG MO 23a. Pirt 1. Effect the dise and, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last by Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Certificate: To Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' To the Funeral Director: After this certificate I completed filled in by the funeral director, page 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 340 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a

To the Funeral certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 2010 cely 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State MAR 08 2010 Registrar

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			1 - State Registrar Certificate of Death Re								Reg. N		1.0	3. Time of Death
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	mine		4a. Facility Name (if not institution, to Washington Ac			i+al			ocation of Deatl	h	4	c. County	of Death	277
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Direc			212-48-4198	1 🛛 M 2 🗆 F	61	Yrs.	Months	Days	Hours Min.	(Month, E 6 – 11	ay, Year) _ 19	48	Coun:	
pur pur	at	, l	Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Loc	ation						1	0d. Inside City Limits
Maryla 28a-f	otitied	Director	MD Carı	coll				Ta	neytow	n				1 🗆 Yes 2 🗆 No
with the	ust be no	Funeral Di	10e. Street and Number 68 B Trevar	nion Rd.			10f. Zip	217	87		10g. (USA	What Coun	itry?
re, INIAL VICILIO ZIZIO-0050 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show	Examiner m	হ	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie 3 ☐∰Vidowed 4 ☐ Divorced	Armed Fo	2 🗌 No e	If	Yes, spec	lent of Hisp cify Cuban, 2 □ X o	panic Origin? (S Mexican, Puert Specify:	pecity Yes or No o Rican, etc.))-	Bla	e - Americ ck, White, e whit	etc.
within 72 hou giene.	the Medica	Completed	15. Decedent (Specify only highes Elementary/Seconday (0-12) 1 2		-4 or 5+)	life. DO	aind of wo O NOT use	rk done du	ring most of wo	rking	16b. Kind of Business Industry Counseling			
should be filed within 72 and Mental Hygiene.	itic event,	To Be	17. Father's Name (First, Middle, Last) Louis V. Guarnera 18. Mother's Name (First, Middle, Maiden Surname Emma Hardy							e)				
e, Mary and 2 should Health and N tem 27 is ma	er trauma		19a. Informant's Name/Relationshi Marie E. Wale		er		_		on Rd.					
Dallinore, permit. Page 1 and 2 Department of Healt Important: If item 2	ury or oth		20a. Method of Disposition 1 ☐ Burial 2 ※Cremation 4 ☐ Donation 5 ☐ Other (Sp		State C	Place of Disposemetery, crem uth Ca	natory or c	ther place)	rem 3/	Date 5/2010	7.7.2		- City or To	
Dallillo permit. Page 1 Department of Important: If i	any inju	21. Signature in uneral Service Licensee 22. Name and Address of Facility Fletcher Funeral Service Licensee 254 E. Main St., Westminster,												
shock, or heart failure. List only one cause on each line.									Approximate Interval Between Onset and Death					
Med Exami	iner		resulting in death) Sequentially list conditions,	Due to	or as a consequ	uerice of):	ock							
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DIVISION OF VITAL MECO. To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has	illed in by		4 Homicide determine	ned 28e. Place buildi	of Injury - At hong, etc. (Specify	<i>(</i>)			-	City or To	own, Sta	te)		Route Number,
n 24 ho	Dieted	Medical	(Check 2 L Medical Ex	Physician: To the b caminer: On the bas Nurse Practioner:	sis of examinatio	n and/or invest	tigation, in	my opinion	, death occurred	at the time, date	e and pla	ce, and du	e to the ca	use(s) and manner stated.
To th within	E00		29b. Signature and title of certifier				29	c. License	number		29d. [Date signe	d (Month,	Day, Year)
5			30. Name and address of person w	rho completed caus	se of death (Iten	1 23a) (Tvpe. F	Print)	71	801		0	171	w,	
4			Oney Einiga	. 4701	Rano	lold	Ro	te	716, R	ocknie	le	, M	2 0	10
Por	Stat		31. Date fled (Month, Day, Year)	010 22. R	egistrar's Sign	ture	Kell							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death March 5, Physician/ Melvin Charles Hoxter 6:30 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Joseph Richey House Baltimore Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours 1 ★M 2 □ F 08/24/1917 Maryland **Director** 215-09-0208 Yrs 92 Usual Residence of Decedent or 28a-f shov 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Examiner must be notified at Director Maryland Baltimore Essex 1 🗌 Yes 2 🛛 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a U.S.A. 1 Ortega Lane "natural", or items permit. Page 1 and 2 should be flied within 72 hours after death Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Race - American Indian, Black, White, etc. Armed Forces?

**XX Yes 2 \sum No 1941—
If Yes, Give δ 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: Specify: White 3XWidowed 4 Divorced Completed 1977 Year or Dates event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Soldier U.S. Armed Forces Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 unknown lunknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mack McCary (Personal Represent) 1 Ortega Lane, Baltimore, Maryland 21221 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Md. Veterans Cem. tXXBurial 2 ☐ Cremation 3 ☐ Removal from State 03/09/2010 Crownsville, Maryland 4 Donation 5 Other (Specify) 21. Signature of Paperal Service Licemes 22. Name and Address of Eacility Bruzdzinski Funeral Home, P.A. Old Fastern Avenue, Essex, Maryland 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician/ disease or condition resulting in death) Medical Due to (or as a consequenc Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter on dening to Cause (Disease or iinjury Due to (or as a consequence of): attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day 9 Unknown 9 Unknown P.O. Part II. Other significant conditions conditions to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an r this certificate has ral director, page 2: autopsy death? 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 2 No 은 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No. 1 Natural 5 Pending Accident Investigation ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, Homicide determined building, etc. (Specify) within 24 hours af To the Funeral Di completed filled in 29a. Certifier Certifying Physician To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: (n the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only on Certifying Nurse Pr ctioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signat

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

MAR 0.8 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		State of Maryland / Department of Health a	and Me	ntal Hygie	ene No 2 0 1 0	06907
		1 - State Registrar Certificate of Death			No LUIU	00001
Physic		1.Decedent's Name (First, Middle, Last) William Robert Jacobs		Date of Death Month Mar 6	2010 Year	3. Time of Death 4:19P M
/Med Exami		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of	of Death		4c. County of Death	1
Forestel		Carroll Hospital Center Westminst 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 1		. Date of Birth	Carroll 9. Birth	place (State or Foreign
Funeral Director		216-34-6659 18 M 2□F 71 Yrs. Months Days Hours	Min.	(Month, Day, You	,1938 MD	intry)
pu.		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
Marylan f show	ğ	MD Carroll Westminst	er			1 □Yes 2 XNo
with the I 3a or 28a	Il Director	10e. Street and Number 406 Baldwin Park Dr., AptA1 21157		10g	. Citizen of What Cou USA	ntry?
and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. It may be marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at	by Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ ★ arried 1 □ Never Married 2 □ ★ arried 1 □ Never Married 2 □ ★ arried 1 □ Yes 2 ★ Specify:		fy Yes or No- can, etc.)	14. Race - Ameri Black, White, Specify: W	
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car y rail of a filed within and Mental Hygiene. Is marked other than aumatic event, the Manager and a file of the Manager	Be	17. Father's Name (First, Middle, Last) 18. Mother		First, Middle, Ma		
2 should and Maria mari	2	19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number				
s 1 and of Health item 27		Mary Jacobs-wife 406 Baldwin Park 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	DE'.	e 20	c. Location - City or T	own, State
permit. Pages 1 and 2 Department of Health Important: If item 27 i any injury or other tra		4 Donation 5 Other (Specify) South Carroll Crem		/ 10	infield, Funeral	
permit. DepartmImports any inju		21. Signature of Funeral Service Licensee 22. Name and Address of Facility 254 E. Mair.	-			
Physician	ı	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	cardiac or r	respiratory arres	it,	Approximate Interval Between Onset and Death
/Medical Examiner		resulting in death) Due to (or as a consequence of):	in 0	ligear	0e	
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for the Hospital or Attending Physician; The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify)			23d. Date of deli	very Day Year
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To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date at 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deat and manner stated.				
To th within To th	Me	29b. Signature and title of certifier 29c. License number	141	14 290	d. Date signed (Month	, Day, Year)
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	100	(C	13/08	12010
2		0295 Stone Ave, Suite 102, Westin	11/151	ter, MD	21157	
Si Regis	tate trar	31. Date filed (Month, Day, Year) 33 Registrar's Signature				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical Month 60 0:32 MARCH 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 1 M M 2 □ F Director Usual Residence of Decedent and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location the Medical Examiner must be notified at Director 1 Yes 2 No 10e. Street and Numbe 10g. Citizen of What Country? Funeral USA 2. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cubart, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🖼 No 3 Widowed 4 Divorced)/ac 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, i Be 7. Father's Name (First, Middle, Last) -Mother's Name (First, Middle, Maiden Surname) 9a. Informant's Name/Relationship (Type 19b. Mailing Address,(Street and Number or Rural Route Number, City or Town, State, Zip Code) かひみづり 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fineral Services 21. Signature of Funeral Service Ligenses Kandalls town, MDD-1133 23a. Part 1. Enter the disease, or of implications that caused the death. Do not enter the mode of dying, such as card, of shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examir the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of attending physician for use as the burial Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate bewithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death
Pregnant at time of death 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No page 2 should be detached for Day Month 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Vunknown MELLITUS 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 🗌 Yes 2 🗀 No 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: ပ 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Gertifying Nume Practioner T. The best of high wedge death accurred at the time, date and due to the cause(s) and manner as stated (Check 29d. Date signed (Month, Day, Year)
MARCH 5-2010. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

31. Date filed (Month, Day, Year)

08

2. Registrar's Signature

7445 FRANACE BRANCH Pd GLENBURNIE Md 21060

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Year 2010 Jacobs 05:44 M urnell Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** of Medical Ctr Baltimore Maryland N/AIf Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Numbe 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 093-42-4426 1 🔀 M 2 🗀 F 59 Months Hours Min. (Month, Day, Yea, 9-8-1950 VIRGIN **Director** ISLAND Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at Director FINKSBURG 1 X Yes 2 □ No MD. CARROLL 10f, Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21048 1705 LAKE FOREST DR. USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces?

1 1 Yes 2 No If Yes, Give Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 X Married Maryland 21215-0036 1 X Yes 2 ☐ No Specify: permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exan Specify: BLACK 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) COSMOTOGY BUSINESS OWNER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file h and Mental h r is marked or ည EDUARDO JACOBS HELENA VALLARD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PATSY JACOBS (WIFE) 1705 LAKE FOREST DR. FINKSBURG, MARYLAND 21048 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 3-5-2010Cremation 3 ☐ Removal from State 5 ☐ Other (Specify) cemetery, crematory or other place) 1 🔀 Burial 4 Donation GARRISON FOREST VETERĀNS DWINGS MILLS, MARYLAND JONATHAN D. HIBN R2. Name and Address of FacilityREDD FUNERAL SERVICE 21. Signature 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Parth Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Findisease condition resulting in death) Onset and Death Cause (Final Ph sician/ VECTOTIZIO Medical Due to (or as a consequence Examiner ararlegia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) etastatic rostate Cancer -transit Exami and that initiated events Due to (or as a consequence of) resulting in death) Last physician a the burial-t Physician/Medical requires that the death certificate be P.O. Box 68760 as the attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death 2 No been signed by the selection should be detached 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? | 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Hospital or name.
24 hours after death.

Funeral Director, After this certificate has become a funeral director, page 2: autonsv performed? death? or Attending Physician: The 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 ☐ Yes 2 🕱 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury work? 1 Yes 2 No 1 Natural 5 Pending Accident Investigation completed filled in by the 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 29a. Certifier 1 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 only one 29b. Signature and title of certifier D0065118 Feb. 20,2010 22 S. Greene Great Baltimory MD 20010

State Registrar

DHMH 17 Rev 7/2009

tancie

31. Date filed (Month, Day, Year)

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Chodes, MD

MAR 0.8 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 10c & 19b, per Fh g901 3/11/10 TT
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No./ 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day Month Year **Physician** Robert 12:50 PM mand 2010 Chaston /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Bowerman Boul Harris L, Lemarsh 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1**√** M 2□ F 219-03-3623 90 Yrs Director 31, 1919 Oct. MD Usual Residence of Decedent 10a State 10h Counts 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at Director MD Baltimore White Mash Marsh 1¥ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 11021 Bowerman Road 21162 USA 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No WW II IYes, Give Year or Dates: US Army items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 🔀 No Specify. Specify: White þ 3 XWidowed 4 ☐ Divorced "natural". Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. 12 should be filed wi h and Mental Hygier 7 is marked other th 12 Postal Worker US Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be (unknown) Rose (unknown) 2 19b. Mailing Address (Street and Number or Rural Route Number, City of Town, State, Zip Code)
11021 Bowerman Road, White Mash, MD 21162 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 st Department of Health and Important: If Item 27 is n any Injury or other traun Robert A. Johnston Jr. / Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State Final Journey Crem. 3/5/2010 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service icent of Dorota Marshall 22. Name and Address of Facility
Maryland Cremation Services PO Box 1431, Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Due to (or a a consequence of): hours disease or condition resulting in death) /Medical Examiner ASCUD YER25 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner law requires that the death certificate be executed 1212 setes VOGILY and burial-trar Due to (or as a consequence of): Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) P.O. 1 □Yes 2 □ No 9 Unknown ģ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ Chronic displace 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? de mes 24a. Was an has page 2 autopsy performed Hospital or Attending Physician: The certificate 2 No 1 □Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 V No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Injury 1 [XNatural 1 □Yes 2 □ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a, Certifier 1 🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 24 the 29b, Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c, License number 3/2/10 D31782 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KLEPSZ Kenwood Baltone 21206 5 701 31. Date filed Wonth, Day, Year) 32. Reistrar's Signature State Registrar MAR 08 2010

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Dav Year William Frederick Jones, Sr. 2010 6:45 P.M March Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Chapel Hill Nursing Home Baltimore Randallstown Social Security Number 9. Birthplace (State or Foreign Country) Maryland 7. Age (In vrs. last birthdav) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth **Funeral** Month, Day Year)
July 6, 1916 1**X**XM 2 □ F Days Director 217-03-3464 93 Usual Residence of Decedent 28a-f show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Baltimore Marvland Woodlawn 1 Yes XX No 10e. Street and Number 9 10f, Zip Code 10g. Citizen of What Country? Funeral 2690 West Park Drive 21207 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married txx Yes 2 No If Yes, Give Year or Dates. Completed by Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after WII 1 ☐ Yes 2 X No Specify: White 3 Widowed 4 ☐ Divorced Specify: injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) Baltimore Concrete College (1-4 or 5+) 7th <u>Foreman and</u> Dispatcher and Mental Hygie is marked other Products Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Frank Jones Katherine 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Dennis F. Jones <u> 2690 West Park Drive</u> Woodlawn, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State March 9, 20110 Lorraine Park Cem. Woodlawn, MD 4 Donation 5 Other (Specify) Funeral Service Licenses 22. Name and Address of Facility Burrier-Queen Funeral Home & 1212 W. Old Liberty Road W. Old Liber Crematory, Approximate Interval Between ediate Onset and Death End-Stage Alzheimers Ph_sician/ Dementia condition Medical ultime in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ___ in the past 12 months? Day Year Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗌 No 1 Yes

To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760

Be (

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Certificate:

Medical

IXU State Registrar

25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2 No Hospital: Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

n Skajapakse M.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

00057465 2835 Smith Av. S-203, Baltimore, MD. 21209.

N'S Rajapakse, M'D 32. Registra s Signa

29b. Signature and title of certifier

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March Day. 2010 Richard Michael 12:05pm M King Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death
Baltimore 4b. City, Town, or Location of Death Examiner Towson Gilchrist Hospice 8. Date of Birth

(Month, Day Year)

Sept. 3, 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Min. Months 1 🔯 M 2 🗆 F 69 Hours 213-38-5229 Director Usual Residence of Decedent or 28a-f show notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 🏋 ☐ No MD Howard Glenelg 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ō and Mental Hygiene. is marked other than "natural", or items 23a or aumatic event, the Medical Examiner must be I Funeral 3210 Roscommon Drive 21737 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11 Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 Divorced 4 Divorced Year or Dates. 1958-60 White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b, Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Cemetery Cemeterian Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Thelma Josephine Moreland Vivion Rutan King 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3210 Roscommon Drive Glenelg, MD 21737 Department of Health a Important: If item 27 is any injury or other trainonce. Mrs. Barbara A. King (Spouse) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State All County Cremation 3/8/2010 Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License HATCHT FUNERAL HOME & CHAPEL, P PO Box 195 Sykesville, MD 21784 100764 an 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Metaslatic Cencer to Brain Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Se wentially list conditions if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury that initiated events resulting in death) Last burial-transi Due to (or as a consequence of): Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be 68760 use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Box 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 Ho
9 Unknown Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown page 2 should be detached Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of autopsy performed death? 1 Yes within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, t 25. Was case referred to medical of Vital Be 26. Place of Death (Check only one) Other: 1 Yes 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural Division 1 Yes 2 D No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check

State Registrar

DHMH 17 Rev 7/2009

99

address of perso

Day, Year,

6701

MA

MB

who completed cause of death (Item 23a) (Type, Print)

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

North

D67236

Charles sheet 21204

29d. Date signed (Month, Day, Year)

Merch 6,2010

Registrar
DHMH 17 Rev 1/2001

State

30. Name and address of person who completed cause ot death (Item 23a) (Type, Print)

32. Registrar's Signature

William F. Harper

31. Date filed (Month, Day, Year)

D17549

180 Thomas Johnson Drive #101 Frederick, MD 21702

2/22/2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Marylar		artment of H rtificate of I			giene _{leg. No.} 2 ()	0 06814
	Physici /Medi		1. Decedent's Name (First, Middle, Las 5 y l v i a Kramer					2. Date of Dea Month	th Day Yea 3 2010	3. Time of Death
	Examir		4a. Facility Name (If not institution, giv			RANDALL			4c. County of De	ORE
	Funeral Director		5. Social Security Number 216-16-1728 Usual Residence of Decedent	ex 7. Age (In yrs. 85	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 9/14/1	9. E	Sirthplace (State or Foreign Country) MD
	Maryland -f show led at	tor	10a. State 10b. County MD BALTIMO		ity, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 🕅 No
	th the	Director	10e. Street and Number	NL DA	IL I I I IOK	10f. Zip Code		1	10g. Citizen of What	 Dountry?
	ath wit		2 CANDLEMAKER C	OURT, #304		21208	3		USA	
036	be filed within 72 hours after death with the Maryland ntal Hygiene. ad other than "natural", or items 23a or 28a-f show event, it a Mariled Exa vit ar must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ◘ Widowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ∐Yes 2∭No If Yes, Give Year or Dates:		Was Decedent of Hi If Yes, specify Cuba 1 □ Yes 2 No	ispanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ar Black, Wh Specify:	nerican Indian, nite, etc. WHITE
5-0	72 hc	etec	15. Decedent's Ed (Specify only highest gra	lucation de completed)	16a. Dece	dent's Usual Occupa kind of work done of DO NOT use retired	ation furing most of worki	ing	16b. Kind of Busines	ss/Industry
Baltimore, Maryland 21215-0036	filed within Hygiene. other than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	OWNE					S CLOTHING
ylanc	2 should be filed withir and Mental Hygiene. is marked other than sumatic event, to the sum of the	To Be	17. Father's Name (First, Middle, Last) HYMAN	HENESON			IDA		GUTIN	
Mai	nd 2 sh lith and 27 is n r traun		19a. Informant's Name/Relationship (*BERNARD HENESON/I	**		ng Address <i>(Street a</i> SMITH AV			r, City or Town, State MD 2120	
ore,	es 1 ar of Hea fitem 3		20a. Method of Disposition 1	20b. F		sition (Name of natory or other place			20c. Location - City	
tim	it. Pag rtment rtant: I		4 □ Donation 5 □ Other (Specify	BET	H TFIL	OH CEMETE	RY 3/5/		BALTIMORE	
Bal	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic es once.		21. Signature of Funeral Service Licen	Lund	8		ERSTOWN F	ROAD, PI	ISON & BRO	S., INC. MD 21208
	Physician /Medical		23a. Part 1. Enter the disease, or compands, or heart failure. List only disease or condition resulting in death)	one cause on each line. End-Stage	Renal	er the mode of dyin	g, such as cardiac d	or respiratory arr	rest,	Approximate Interval Between Onset and Death
	Examiner			Due to (or as a conseq	uence of):					
	ed sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	juence of):					
ζ.	execut n and ial-tran	Examiner	that initiated events resulting in death) Last	cDue to (or as a conseq	juence of):					
68760	ificate be executed g physician and is the burial-transit	edical		d						
O. Box	death cert e attending d for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregnation 1 Live birth 2 Feta 4 Pregnant at time of a 9 Unknown	aldeath 3	Ectopic pregnancy Other (specify)	/		23d. Date of o	delivery Day Year
rds, P.	law requires that the das been signed by the 2 should be detached	ρ	Part II. Other significant conditions of	ontributing to death but not res	ulting in the ur	nderlying cause give	en in Part I.			to the cause of death?
Division of Vital Records,	The law rec ate has bee page 2 shou	Completed						24a. Was a autops perfori	sy prior t med2 death	
/ital	ctor, p	BeC	25. Was case referred to medical examiner?				26. Place of Death		2 🗹 No	es 2□No
of	Physic rthis c		1 ☐ Yes 2 ☑ No 27. Manner of Death	Hospital: 1 ☐ Inpatient 2 ☐ 28a. Date of Injury	ER/Outpatier		er: 4 Nursing Ho			pecify) hospice
ion	Attending Physician: r death. ector: After this certific. by the funeral director, I	ation	1 Natural 5 Pending 2 Accident investigation	(Month, Day, Year)	Injury	Work	? ?	zad. Describe no	ow injury occurred	
Divis	al or Atte s after des I Directo	Certification: To	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, stre fy)	eet, factory, office		28f. Location (Si City or Town	treet and Number or n, State)	Rural Route Number,
1	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical C		ysician: To the best of my kno liner: On the basis of examina and manner stated.						
<i>"</i>	To the within To the comp	Me	29b. Signature and title of certifier MSRAPARSE M.	0.		29c. License D 0 0	97 465	2	29d. Date signed (Mo	
			30. Name and address of person who o	completed cause of death (Item 2835 Sm	n 23a) (Type, I	Print) , S - 203,	Bathmore,	,MD.21	209.	
	Sta Registr	.~	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture	6				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1- State of Maryland / L	Department of F Certificate of I			giene Reg. No.	0 05815	
	Physici		1. Decedent's Name (First, Middle, Last) Mary Jane Lindblad			2. Date of Dea Month March	Day Year 5, 2010	3. Time of Death 4:50 pm M	
-	/Medio Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or	Location of Death	riai cii	4c. County of Dea		
-01			Fairhaven Health Care Center	Sykes	sville			roll	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last bir. 1 ☐ M 2 1 7 88	8, Date of Birt (Month, Da July 1	9. Bi 4, 1921	rthplace (State or Foreign ountry) D.C.			
	land ow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	or Location		<u> </u>		10d. Inside City Limits	
	Mary a-f sh	tor	MD Carroll	Sykesy	ille			1 ☐ Yes 2√ No	
	or 28	Director	10e. Street and Number	10f. Zip Code			10g. Citizen of What C	ountry?	
	s 23a	rall	7200 Third Avenue		.784		US		
36	should be filed within 72 hours after death with the Maryland of Mental Hyglene. marked other than "natural", or items 23a or 28a-f show marked other than "natural", or items 23a or 28a-f show marked other than "baffeal Examine must be restlined at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give X Year or Dates:	13. Was Decedent of H If Yes, specify Cuba 1 □ Yes 2 □ No	ispanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)		erican Indian, te, etc. Ihite	
5-0036	2 hour	ted	15. Decedent's Education 16a.	Decedent's Usual Occup	ation		16b. Kind of Business		
215	thin 72 ie.	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind of work done of life. DO NOT use retired		ing			
2	filed wi Hygier other th			Homemaker		· /Fire Added		estic	
Maryland	be od od	To Be	17. Father's Name (First, Middle, Last) Eugene Moore		Mary Mary	_	Maiden Surname) ⊇r		
Mar	d 2 s th at 7 is trau			Mailing Address (Street a			-		
a)	1 an Heal em 2			1130 K Chamb Disposition (Name of ry, crematory or other place		Date	20c. Location - City of		
Ë	Pages nent of ant: If its ary or o		TELEBOTIAL 2 Experimation 3 Experimovarition State	y, crematory or other plac unty Cremati	i .	2010	Sykesville	. MD	
Baltimore,	permit. Pages Department of Important: If it any Injury or o once.		21. Signature of Funeral Service Licensee				PEL P.A.	, 120	
			23a. Part 1. Enter the disease, or complications that caused the death. Do r shock, or heart failure. List only one cause on each line.					Approximate Interval Between	
1	Physician		Immediate Cause (Final disease or condition	ral infar	Levis			Onset and Death	
	/Medical Examiner	Due to (or or a consequence of):							
		e.	Sequentially list conditions, if any, leading to immediate. Due to (or as a consequence of	of):					
	cuted nd ransit	Examiner	Sequentially list conditions, if any, Lauring to immediate cause. Enter Underlying Cause (Disease or injury that initiated events						
Ď,	be exe cian a purial-t		resulting in death) Last Due to (or as a consequence of	of):					
09/90	ficate physi s the b	edical	d						
C. Box	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 Hours after death. Within 24 Hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 poinths? 1 ☐ Yes 2 No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	23d. Date of de Month	,				
τ.	s that t ned by detac		Part II. Other significant conditions contributing to death but not resulting in	the underlying cause give	en in Part I.	23e. Did to	ob <i>a</i> cco use contribute t	o the cause of death?	
ecords,	equires en sig vuld be	Completed by	Congestive heart feature	2		1 🗆 Y	/es 2 No 3 F	Probably 4 ☐ Unknown	
သ	law re nas be	plet	atrial flollation.		.,,,,,	24a. Was		utopsy findings available completion of cause of	
E S	r: The	5	0			perfo	rmed? death?		
N I	siclar certif rector	Be	25. Was case referred to medical examiner? Hospital: Hospital:	Othe	26. Place of Deati				
5	g Phy: er this eral di	n: To	27. Manner of Death 28a. Date of Injury 28b. T	ime of 28c. Injury	44 Nursing Ho		dence 6 Other (Spenow injury occurred	ecify)	
INISIOU OI	endin sath. or: Aft he fur	atio	2 Accident investigation		r res 2□No				
Š	al or Att s after de l Direct	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, far building, etc. (Specify)	m, street, factory, office		28f. Location (5 City or Tow	Street and Number or F vn, State)	lural Route Number,	
	re Hospitt	Medical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge 2 Medical Examiner: On the basis of examination and and manner stated.	, death occurred at the tin d/or investigation, in my o	ne, date and place, pinion, death occur	and due to the red at the time,	cause(s) and manner a date and place, and du	as stated. e to the cause(s)	
	vithii To th	ž	29b. Signature and title of cartifier	29c. License			29d. Date signed (Mon		
				D34	849	/	Mach 8	2010	
	0		30. Name and address of person who completed cause of death (Item 23a) (William Tan MD 1645	Type, Print)	RIE.	Wess 5	Mach 8 wo MD	21784	
	Stat Registra		31. Date filed (Month, Day, Year) MAR 0.8 2010	ale					

DHMH 17 Rev 1/2001

10-01431 Rosa Mayela Moren			e or Print in Black Indelible Ink. Ensure All Copicate of Maryland / Department of Health and Mental H	-	le.	0 0001
	1- For State Registrar		Certificate of Death	Reg. No	<u> </u>	0 0681
Physician/ Medical Examiner	1. Decedent's Name Rosa	(First, Middl	e,Last) Moreno	2. Date of Death Month Day February 17, 2	Year 2010	3. Time of Death 0805 hrs

		Registrar	tificate of	Death			Reg. No.	
Physic Jedical Exam		110 11010110	2. Date of D Month Februar	Day Year Y 17, 2010	3. Time of Death 0805 hrs			
		4a. Facility Name (if not institution, give street and number) 20411 Apple Harvest Circle, Apt. P	ľ	4b. City, Town, o Germanto		eath	4c. County of Death Montgomery	
Funeral Director		5. Social Security Number 218-35-0010 6. Sex 1 7. Age (In yrs. las	st birthday) Yrs	If Under 1 Ye Months Da		Min	Birth(MM/DD/YYYY) 4/1963	9. Birthplace (State or Foreign Venezuela Country)
any		Usual Residence of Decedent 10a, State 10b, County 10c, City, T	Town or Locati	ion				10d. Inside City Limits
*	L	MD North Con	rmantov					1 Yes 2 X No
ne Maryland or 28a-f show fied at once.	윷	10e. Street and Number		10f. Zip Code			10g. Citizen of Wh	at Country?
th the M 23a or 2 notified	I Director	20411 Apple Harvest Circle, Apt		20876			USA	
ath wi items	Funeral	11. Marital Status 1 Never Married 2 X Married Armed Forces?		s Decedent of H es, specify Cuba		(Specify Yes or erto Rican, etc.)	No- 14. Race White	- American Indian, Black, , etc.
fter de l'', or		3 VVIdowed 4 DIVOICED III Tes, Give Tear	1 X	Yes 2 N	o specify.Ve1	nezuelan	Specify:	White
nours a	ed by	15. Decedent's Education (Specify only highest grade completed)	16a. Deceden	t's Usual Occupa			16b. Kind of Bus	siness/Industry
5-0036 led within 72 hours af Hygiene. other than "natural" the Medical Examin	ompleted	Elementary/Secondary (0-12) College (1-4 or 5+) 5+		torney	o. 50 NoT us o	10.1104)	Law	
5-0036 led within 7 Hygiene. other than	Com	17. I differ a Name (I first, Middle, East)			18.Mother's Na	ame (First, Middle	e, Maiden Surname)	
1215 be fill ental H arked	Be	Antonio Jose Moreno					es Orozco	
nore, MD 21215-0036 ages I and 2 should be filed within 72 hours after death with the Maryland ent of Health and Mental Hygenes. The file of the filed with the Medical Examiner must be notified at once other traumatic event, the Medical Examiner must be notified at once	To	19a. Informant's Name/Relationship (Type, Print) Jose J. Dudamel - Husband						ermantown, MD
Baltimore, MC permit. Pages I and 2 s Department of Health an Important: If item 27 injury or other trauma			ace of Disposi ematory or oth	ition (Name of co er place)	emetery,	Date	20c. Location -	City or Town, State
Baltimore, permit. Pages I ar Department of Hea Important: If ites					7		ľ	ndria, VA
Bal permi Depar Impo injury		21. Signature of Funeral Service Licensee Terence L. McHugh per DVR						Funeral Home er Spring, MD
Physician		23a. Part I. Enter the disease, or complications that caused the death. D				•		rt Approximate Interval
/Medical Examiner		failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Acute Coronary Due to (or as a consequence of):		bosis				Between Onset and Death
	_	Sequentially list conditions, b		·				
	miner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause						
ecuted and transit	Exan	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):						
al al	n/Medical	x UNPENDED AMENDED # 21 per 23a,pt.II	fh, g90	01,03/08	3/201041	ıb		
8760, tificate be ex ng physician as the burial	/Me	IF FEMALE: 23c. If yes, outcome of pregna	incy				23d. Date of d	delivery
c 68 certif ending use as		past 12 months? 1 Live birth Pregnant at time of deatl	h \Box	al death 3 ner (Specify)	Ectopic pre	gnancy	Month	Day Year
Box e death c the atten ed for us	Physicia	1 Yes 2 No 9 V Unknown 9 Unknown	- [Out					
P.O. Box 687 s that the death certifi gned by the attending e detached for use as t	by P	Part II. Other significant conditions contributing to death but not rest	ulting in the ur	nderlying cause	given in Part I.			oute to the cause of death?
es is e	ted	Obesity, Smoking						Probably 4 Unknown Vere autopsy findings available
n of Vital Records, P.C. ing Physician: The law requires that After this certificate has been signed timeral director, page 2 should be dete	Completed					aut	opsy pr	for to completion of cause of eath?
Re : The ificate r, page	So	25. Was case referred to medical		20 DI-	(D 1) (C)	1 ✓ Yes		✓ Yes 2 No
/ital	Be	examiner? [Hospital: ,] lengtions 2 [F	R/Outpatient		e of Death (Che Other ₄ Nur	rsing Home 5	Residence 6	Other Scene
of \officers	2	27. Manner of Death 28a. Date of Injury (Month Day Year)	8b. Time of In		ury at Work?		e how injury occurre	
ion frendi	atio	1 X Natural 5 Pending 2 Accident Investigation		1	Yes 2 No			
Division of Vital Records, To the Hospial or Attending Physician: The law requir within 24 hours after death To the Funeral Director: After this certificate has been s completely filled in by the finneral director, page 2 should the	Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At hom	e, farm, street	t, factory, office	building, etc.	28f. Location or Town		or Rural Route Number, City
Hospit 24 hour Funera	<u>S</u>	4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge,	, death occurr	ed at the time, d	ate and place, a	and due to the ca	use(s) and manner a	as stated
No the vithin 2 to the omplet	Medical	one) 2 Medical Examiner: On the basis of examination and						
S 29b Signature and title of certifier 29c. License number 29c. License number								d (Month, Day, Year)
	ļ	Cicle Valler Velk		O.C.	M.E.		February 18	, 2010
		 Name and address of person who completed cause of death (Item 23 Victor Weedn MD JD Assistant Medical Examine 	•	enn Street, E	Baltimore. M	D 21201		
St	ate			in .				
Regist	rar	31. Date filed (Month, Day, Year) 32. Registrar's Sinature						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2010 Physician/ Dorothy Strawsburg McKinney Mar 9:25A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Sykesville Transitions Healthcare Carroll 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🎛 F Hours Months Days Min. (Month, Day, Year, Country) 216-38-2933 Director MD Tun Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Carroll Manchester 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1931 Hoover Mill Rd. 21102 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. Yes 2 14No ģ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Specify: White 3 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) 72 permit. Page 1 and 2 should be filed within 72. Department of Health and Mental Hygiene. Important if frem 27 is marked other than any injury or other traumatic event the second of the School Elementary/Seconday (0-12) College (1-4 or 5+) Teacher 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Arnold Strawsburg Madeline Green 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21 10 🥫 19a. Informant's Name/Relationship (Type, Print) 1931 Hoover Mill Rd., Manchester, MD Raymond E. McKinney-husband Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 3/19/10 1 Burial 2 Cremation 3 Removal from State Westminster, MD 4 ☐ Donation 5 ☐ Other (Specify) Meadow Branch Cem Signature Juneral Service Licensee 22. Name and Address of Facility Fletcher Funeral Rome Homas 254 E. Main St., Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Medical resulting in death) **Examiner** Sequentially list conditions, Examine il any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury anding physician and use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy for in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) been signed by the a should be detached Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, 1 Yes 2 No 3 Probably 4 Whithown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an or Attending Physician; The law page 2 autopsy performed' death? certificate 1 Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes Other: မ 4 Harsing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this funeral Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending within 24 hours after death.

To the Funeral Director: A Accident Investigation Could not be the Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined City or Town, State) Hospital Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the ess of person who completed cause of death (Item 23a) (Type, Pript)
away B. Kanere, 343 Malalm dury werrminim MD 21157

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Рау **Physician** Virginia Jane MacMillan March 11:00 A M 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Roland Park Nursing Home Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours 1 □ M 2 🔽 231-66-6204 91 May 15, 1918 MA Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Director MD Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 830 West 40th. Street USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Dyes 2 □ No US Army If Yes, Give Year or Dates:1941-45 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White q 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Health Care Nurse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jeannette Keator Thompson Edgar 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John R. MacMillan / Son 435 Cervantes Road, Portola Valley, CA 94028 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Fremation 3 ☐ Removal from State Final Journey Crem. 3/6/2010 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Maryland Cremation Services
PO Box 1413, Baltimore, MD 21203 21. Signature of Funeral Service License Dorota Marshall W marshall. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Udvanced atheroscleretie cardiovascular disease ears Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner Due to (or as a consequence of)

Physician /Medical Examiner

Funeral

Director

notified at

Examiner must be

event, the Medical

I Hygiene.

marked other

Department of Heali Important: If item 2 any Injury or other

Health and Mental em 27 is marked o Pages 1 and 2 should be

natural", or items 23a or 28a-f show

death v

72 hours after

Maryland 21215-0036

Baltimore,

and

attending physician

signed by

nas page 2 certificate

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, t

as the

for

þ

Completed

Be

P

Certification:

Medical

requires that the death certificate be executed

Box 68760.

Division or Vital Records, P.O.

Physician/Medical

9 Unknown

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No

23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

4□Pregnant at time of death a I Inknown

3 Ectopic pregnancy 5 Other (specify)

Month Day

23e. Did tobacco use contribute to the cause of death? 1 □ Yes 2 No 3 Probably 4 Unknown

23d. Date of delivery

24a Was an 1 Yes 2 No 26. Place of Death (Check only one)

28d. Describe how injury occurred

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Year

25. Was case referred to medical examiner? 2 7 No 1 ☐ Yes 2 ☐ ER/Outpatient 3 ☐ DOA 1 Inpatient 27. Manner of Death 1 Natural 5 Pending investigation

6 Could not be

Vlac

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier

17 Tealello

29c. License number D13657

29d. Date signed (Month, Day, Year) March 5,2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M-ISABELLE MARGREGOR, 830 W. 40 4 STREET, BALTIMORE, DED ZIZII

State Registrar

31. Date filed (Month, Day, Year) --Eren

and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #1 &23e, per MD g901 3/18/10 TT

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2, Date of Death 3. Time of Death Miller Louis William Miller Physician/ Month ARC Day 8:30FM Medical 4a. Facility Name (if not institution, give street and number)
Saint Joseph Medical 4b. City, Town, or Location of Death Examiner 4c. County of Death Center OWSON Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | A p (Month, Day) 1 Year 27 Social Security Number 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 212-24-1306 1 🙀 M 2 🗆 F 82 Marwon and Director Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho amy injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic and any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Timonium 1 ☐ Yes 2 🛛 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21093 44 East Timonium Road U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 2 □ No '45-'53 Black, White, etc. X Yes þ 1 ☐ Never Married 2 💢 Married Maryland 21215-0036 1 Yes 2X No Specify: If Yes, Give Specify: White Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Financial Exectutive Computers/Credit Union Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Joseph Clinton Miller Nellie Boettcher George 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 44 E. Timonium Rd., Timonium, MD Marylea H. Miller-wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State Dulaney Valley 3/8/10 Timonium, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee William G. Dau 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd., Towson, MD 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ MYOCARDIAL INFARCTION CARDIAC ARREST disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner PULMONARY EDEMA Ecquentially list sor ditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): HYPOXEMIA Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Certificate: To Be Completed by Physician/Medical ACIDOSIS ASYSTOLE Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Yes 2 No 1 Tyes 24 hours after death.

Funeral Director: After this certifical leted filled in by the funeral director, in 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes Other: 2 [1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of De Th 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Acciden 3 Suicide 5 Pending work? 1 ☐ Yes 2 ☐ No. Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DØØ68861 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. 7601 OSLER DRIVE TOWSON, MARYLAND 21204

State

Registrar

31. Date filed (Month, Day, Year)

MAR 08 2010

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Betty Jo Nix March 3, 2010 10:30 A M /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Towson Baltimore Edenwald If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 3/12/1922 Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Year) 424-14-1982 1 □ M 2 □ F 87 Yrs ATabama Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the "Musical Evantinar must be notified at angles." 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD 1 ☐ Yes 2 ☐ No Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 800 Southerly Road Apt 307 21286 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 þ 1 □Yes 2XXNo Specify: Specify: White 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired)

HOMEMORY Elementary/Secondary (0-12) College (1-4or 5+) Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clyde Lee White Hattie Pearl Green ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) D. Randall Nix / Son 204 Governors Road Milton, New Hampshire 03851 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State St. James Episcopal Cem. 3/6/2010 Monkton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Towson, Maryland 21204 Ruck Towson Funeral Home, Inc. 1050 York Road 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Alzheiner's DISEASE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Chief underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 pronths? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2 X No 3 Probably 4 Unknown certificate has been s rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 □ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes Certification: To 28a. Date of Injury (Month, Day, Year) 27. Magner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending Investigation 1 ☐ Yes nours after death neral Director: / filled in by the f 2 🗌 No 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a

To the Funeral C

completely filled 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29b. Signature and title of certifier 29c. License number

State

Registrar
DHMH 17 Rev 1/2001

800 Southerly Ra

R154032

Towson, MD

CRNP

32. Registrar's Signatu

schen

on*th, Day, Year)*

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 06821 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March 07ªy Edwin Albert 20°10 Noyes 5:30 a Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Towson Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 **X** M 2 □ F Months Days Hours Min. Now 12, 1926 Director 83 Yrs Ma"The 006-22-3379 Usual Residence of Deceden show 10a, State 10b. County iral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Md. Baltimore Timonium 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 210 Cinder Road 21093 USA 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. à 1 Never Married 2 Married Maryland 21215-0036 er than "natural", (1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed White Year or Dates Decedent's Usual Occupation
 Give kind of work done during most of working 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) al Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Superintendent Baltimore County Be Department of Health and Mental Hy Important; I frem 27 is marked oth any injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Kenneth Noves Pauline Currie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Doris Noyes/ Wife 210 Cinder Rd. Timonium, Md. 21093 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Service Co. 3-8-2010 Hilltop Towson, Md. 21. Signature of Funeral Arvice Licensee Towson Funeral Home, York Rd. Towson, Md. 23a. Part 1. Enter the diseale, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure! List only one cause on each line Interval Between Immediate Cause (Final Bledder Onset and Death Physician/ disease or condition resulting in death) Cance "Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examir use as the burial-transit Cause (Disease of linjury or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ for in the past 12 months?
1 Yes 2 No Pregnant at time of death Month 1 Yes 2 9 Unknown page 2 should be detached signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown been 24a. Was an 24b. Were autopsy findings available certificate has prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performed?

1 Yes 2 No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: Certificate: To this 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of s after death.

I Director: After to the funers of in by the funers. 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State within 24 hours a To the Funeral D To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D67536 ho completed cause of death (Item 23a) (Type, Print) Belimore Manyle 6 Nortecl

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Carmela Mary Poremski :20p March 6 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Hospice Care Timonium Baltimore **Funeral** Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🖳 F Months Davs Hours Min. (Month, Day, Year) Director 216-40-0373 66 Maryland 30-1943 Usual Residence of Decedent show 10a. State 10b. County at 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified 28a-f MD Baltimore Nottingham 1 🗆 Yes 2 🔽 No 10e. Street and Number 5 10f. Zip Code 10g. Citizen of What Country? Funeral 5 Lona Court 21236 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 1. Marital Status 14. Race - American Indian, Armed Forces' 0 Black, White, etc. Completed by 1 Never Married 2 😾 Married 1 Yes 2 No Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: 3 Widowed 4 Divorced Specify: White Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) In own home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pietro Piunti Mary Mirabile 19a. Informant's Name/Relationship (Type, Print) Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John W. Poremski Lona Ct. Baltimore, Maryland 21236 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) Burial 2 Cremation 3 Removal from State 3-10-2010 Baltimore, Maryland Donation 5 Other (Specify) Oaklawn 22. Name and Address of Facility Joseph N 21. Sign ture of Funeral Service Licensee Zannino cesemes S.Conkling St.Balt 263 234. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final / Onset and Death Physician/ disease or condition resulting in death) UTERINE CANCER Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): dause (Disease or impury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death 9 I Inknown 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 XNo 3 ☐ Probably 4 ☐ Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 X N 1 Yes 2 No of Vital 25. Was case referred to medical examiner? Certificate: To Be 26. Place of Death (Check only one) Hospital 2 X No Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE sted filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 X Natural iniury 5 Pending work? Division Accident Suicide 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the I within 2 only one) 29b. Signature a 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Genera S.

2300 DULANEY VALLEY RD.

ORIGINAL

32. Registrar's Signature

TIMONIUM.

MD 21093

CRNP

JACKIE JONES,

31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

2010

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MARCH

CARMELA POREMSKI

			Please Type or Print in Blac		•	_	
			_ State	Department of Health and I Certificate of Death	Mental Hygi	ene 2010	06823
			Registrar 1. Decedent's Name (First, Middle, Last)	Certificate of Death	Reg	g. No.	
	Physicia Medic		Barbara Jane Ph	illips	Month March 4,	Day Year	3. Time of Death 7:15 a M
	Examin	er	4a. Facility Name (if not institution, give street and number) Upper Chesapeake Hospital	4b. City, Town, or Location of Death Bel Air	1	4c. County of Death Harf	ord
Ī	Funeral Director		5. Social Security Number 212-40-5605 6. Sex 1 □ M 2 ▼ F 7. Age (In yrs. last birth	9. Birti Cou	hplace (State or Foreign intry)		
	d t	_	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	orlogation	<u> March 24</u>	7, 1,776.	10d. Inside City Limits
	//arylan 8a-f sh tified a	recto	MD Harford	Darlington			1 ☐ Yes 2√2 No
	with the 1 23a or 2 st be no	Funeral Director	10e. Street and Number 1998 Castleton Road	10f. Zip Code 21034	10	g. Citizen of What Co USA	untry?
	death v items		11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- o Rican, etc.)	14. Race - Amer Black, White	
980	rs after rral", or Exami	ed by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates.	1 ☐ Yes 2 🖾 No Specify:			ite
75-6	72 hou n "natu Aedical	Completed	(Specify only highest grade completed)	Decedent's Usual Occupation Give kind of work done during most of work life. DO NOT use retired)	king 10	6b. Kind of Business I	ndustry
212	within /giene. ner tha		Elementary/Seconday (0-12) College (1-4 or 5+)	Store Clerk		Retai	.1
0 07(5 am Maryland 21215-0036	d be filed Jental Hy Irked ott Itic even	To Be	17. Father's Name (First, Middle, Last) George Francis Phillips		ne (First, Middle, Ma lian Lee		
(O)	d 2 should alth and h			Mailing Address (Street and Number or Rui 024 Ellicott Dr., B			Code)
3 4 nore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 Burial 2 XCremation 3 Removal from State cemeters	Disposition (Name of crematory or other place)		Oc. Location - City or	
3/4 Baltimo	permit. P Departm Importar any injur		21. Signature of Funeral Service Licensee prota Marshall	ourney Crem. 3/6/ 22. Name and Address of Facility Maryland Cremati		Woodbine,	MD
	90 E B 9		Doube W- Marshall	<u> PO BOX 1413, Bal</u>	timore, M	D 21203	
	≺nysician/ Medical		23a. Part 1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	ma	or respiratory arrest	,	Approximate Interval Between Onset and Death
	Examiner		Branchit	15			TWEEK
	rted 1 Insit	Examiner	Sequentially list conditions, if any hearing to make a constitution of the cause. Enter Underlying Cause (Disease or linjury)		7.4	
	be executed sician and burial-transit	cal Ex	that initiated events resulting in death) Last C. Due to (or as a consequence of):			
982	icate b physi s the b	ledic	d				
\{\co52152\ rds, P.O. Box 68760	Attending Physician: The law requires that the death certificate be executed ar death. sctor: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transi	Completed by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3		23d. Date of deli Month	very Day Year
18005 ds, P.O.	requires that the de been signed by the should be detached	ed by Pl	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tobac	cco use contribute to	the cause of death?
چ و ا	sician: The law re certificate has be lirector, page 2 sho	Comple			24a. Was an autopsy performe	prior to c	opsy findings available ompletion of cause of
)यु	sician: certific rector,	Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Nonetient 2 F8/Out	26. Place of Death (Chec			
Barbara n of Vital R	g Phys er this neral di	te: To	27. Manner of Death 28a. Date of injury 28b. Ti	me of 28c. Injury at	ome 5 Residence 28d. Describe how	ce 6 Other (Specifing Injury occurred	(y)
3 E	ttendin death. tor: Aft	Certificate:	2 Accident Investigation	ury work? M 1 ☐ Yes 2 ☐ No			
Divis	tal or Airs after al Directed in by		4 Homicide determined 28e. Place of Injury - At home, farr building, etc. (Specify)	n, street, factory, office	28f. Location (Stree City or Town, S	et and Number or Rura State)	al Route Number,
Phillips Divis	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completed filled in by the funer	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, d 2 Medical Examiner: On the basis of examination and/or Certifying Nurse Practioner: To the best of my knowle	investigation, in my opinion, death occurred a	t the time, date and r	place, and due to the ca	ause(s) and manner stated.
	To t with To t		29b. Signature and title of certifier	29c. License number + 1006 7817		n. Date signed (Month, March 4, 2	
4			30. Name and address of person who completed cause of death (Item 23a) (Ty WALL BUM, 500 Upper Un japank	upe, Print) LDr. Bel Ar, N	1D 21	014	
~	Stat Registra	e	31. Date filed (Month, Đay, Year) 32. Pegistrar's Signatury	ball		,	
1			THAI VO LUIVI AND THE STATE OF	/			

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	For State Registrar	State of Marylan	d / Department of F Certificate of L	Health and M Death	lental Hygier		06825
Physician/ Medical	ADU	-,,	NER		2. Date of Death Month FEBRUARY		3. Time of Death 2:15 PM
Examiner	4a. Facility Name (if not institution	on, give street and number)	4b. City, Town, or BOWIE	Location of Death		4c. County of Death	
Funeral Director	5. Social Security Number 579–15–8270	6. Sex 1 M 2 D F 7. Age (In yrs. Ia	Ast birthday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yea SEPT . 28	9 Birthr	place (State or Foreign try) RRA LEONE
he Maryland or 28a-f show i notified at	Usual Residence of Decedent 10a. State 10b. Count MD PRIM		y, Town or Location				0d. Inside City Limits 1X Yes 2 □ No
teath with the items 23a or items 2be not er must be no	10e. Street and Number 4202 TAVER	N GREEN LANE	10f. Zip Code 20720		10g. US	Citizen of What Cour	try?
S - 1.5	1 ☐ Never Married 2 💢 Ma	11.37		n, Mexican, Puerto F	cify Yes or No-	14. Race - Americ Black, White, e Specify: BLAC	etc.
Maryland 21215-0036 2 should be filed within 72 hours after th and Mental Hygiene. 27 is marked other than "natural", o traumatic event, the Medical Exam To Be Completed by		ent's Education lest grade completed) College (1-4 or 5+) 2 YRS	16a. Decedent's Usual Occup (Give kind of work done of life. DO NOT use retired) HEALTH CARE	ation luring most of workin	ng l	. Kind of Business Inc	lustry
ryland ; uld be filed v d Mental Hyg marked othe natic event,	ALIEU RENN	ER		TAMU LA	(First, Middle, Maide ASCANDRY	en Surname)	
9, Ma and 2 sho dealth and em 27 is u		PALMER RENNER/WIF					
Saltimore, bearting te, bermit. Page 1 and Department of Hee mportant: If item any injury or other once.	20a. Method of Disposition 1 ▼Burial 2 □ Cremation 4 □ Donation 5 □ Other	3 Removal from State ce	ace of Disposition (Name of emetery, crematory or other place E OF HEAVEN	o) Da	ĺ	Location - City or To	wn, State G, MARYLAND
permit permit Depart Impor	ture of Fue ral Service	Licensee	22. Name and Addres		B. JENK	INS FUNERA	L HOME
Pnysician/ Medical	23a. Part 1. Enter the disease, of shock, or heart failure. List immediate Cause (Final disease or condition resulting in death)	r complications that caused the death only one cause on each line. a. MALIGNANT	. Do not enter the mode of dying NEOPLASM	g, such as cardiac or	respiratory arrest,		Approximate Interval Between Onset and Death
Examiner	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conseque					
cate be executed physician and sthe burial-transit	Cause E for Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	c. Due to (or as a conseque				:a]	
ficate be ey g physician as the buria		d					
Attending Physician: The law requires that the death certificate be executed a datending Physician: The law requires that the death certificate be executed or death set this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit artificate: To Be Completed by Physician/Medical Exam	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No g ☐ Unknown	23c. If yes, outcome of pregnan- 1 ☐ Live Birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	death 3 Ectopic pregnancy	/		23d. Date of deliver	y Day Yea r
v requires that the speed by should be deta	Part II. Other significant conditi	ons contributing to death but not resul	Iting in the underlying cause give	en in Part I.	l _	use contribute to the	
idan: The law require certificate has been si rector, page 2 should law Be Completed	25. Was case referred to medical		26 Pla	ce of Death (Check o	24a. Was an autopsy performed?	prior to com death?	sy findings available pletion of cause of
hysician: his certifi I director, To Be	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ E	R/Outpatient 3 DOA Other			6 ☐ Other (Specify)	
or the Hospital or Attending Physical County within 24 hours after detail. To the Funeral Director: After this completed filled in by the funeral dimedical Certificate: To	27. Manner of Death 1 X Natural 5 Pendi 2 Accident Investi 3 Suicide 6 Could	ng (Month, Day, Year) gation		at 28	d. Describe how inju		
oital or A urs after ral Direc illed in by	4 Homicide determ	building, etc. (Specify)	ne, farm, street, factory, office	4	City or Town, Stat	,	,
o the Hospita ithin 24 hours o the Funeral ompleted fille	Check Z I Medical I	Physician: To the best of my knowled xaminer: On the basis of examination a Nurse Practioner: To the best of my knowledge.	and/or investigation, in my opinion knowledge, death occurred at the	, death occurred at th time, date and place,	e time, date and plac and due to the cause	e, and due to the caus (s) and manner as stat	e(s) and manner stated. ed.
4 % # %	H			7010Z	29d. D	ate signed (Month, Da -26-/	ay, Year)
4)	IVAN ZAMA N	who completed cause of death (Item 2 I.D. 9200 BASIL C	3a) (Type, Print) COURT # 200 LAR	GO,MARYLA	ND 20774		
State Registrar	31. Date filed (Month, Day, Year)	32. Registrar's Signatur	fall				

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 3. Time of Death Decedent's Name (First Middle | ast) 2. Date of Death Physician/ ullivan march 2010 fowm. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** NA Good Samaritan Hospital Baltimore 7. Age (In yrs. last birthday) 6. Sex Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 □ M 2 🔀 F Hours (Month, Day, Year) 06 - 26 - 38 Director 216-26-7540 if item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County with the Maryland Funeral Director 1 X Yes 2 No MD NA Baltimore 10f. Zip Code 21212 10g. Citizen of What Country? 10e. Street and Number 5510 Lothian Road be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc.African 1 Never Married 2 Married Completed by Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: American 3 Xidowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12th Grade ŇΑ Domestic other homes Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Mae Bell Lindsey George M. Lindsey permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Jerry Sullivan-Son</u> 510 Lothain Road Baltimore, MD 21212 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1XXBurial 2 Cremation 3 Removal from State Garrison Forest 03-17-10 Owings Mills, 4 ☐ Donation 5 ☐ Other (Specify) Wylie Funeral Home P.A. 22. Name and Address of Facility 21. Signature of Funeral Service Life 638 Gilmor Street Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only of a cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physiciana uman disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Errier Underlying Cause (Disease or linjury that initiated events Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 70 as been signed by the atte 2 should be detached for Month Year Day Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? Yes 2 No page 1 🗆 Yes 2 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: Certificate: To ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending after death. 1 Tyes 2 No Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined City or Town, State, 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one 29b. Signature completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 7/2009

31. Date filed (Month, Day, Year)

<u>0.0</u>

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** 4:20 P M Smith, Jr. February Albert Lee 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Carroll Hospice Dove House Westminster If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours 1 X M 2 □ F Vrs Director 68 Feb. 19, 1942 Maryland 218-40-9823 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show 1 X Yes 2 □ No Director Maryland Carroll Hampstead 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 23a or Pages 1 and 2 should be filed within 72 hours after death with 1368 Lare St. 21074 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ☐Yes 2 Yes, Give 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: þ White 3 Widowed 4 Divorced Year or Dates 'natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) road construction/ Elementary/Secondary (0-12) College (1-4or 5+) excavating 9 heavy equipment operator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဥ Albert Lee Smith, Sr. Rose Mary Snyder 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If item 27 is any Injury or other trau once. Sarah E. Smith/ wife 1368 Lare St. Hampstead, MD 21074 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3/3/2010 Libertytown, MD Fairmount Cemetery 22. Name and Address of Facility Hartzler Funeral Home Signature of Funeral Service Licenses atharine (11802 Liberty Rd. Libertytown, MD 21762 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Myclodyspla **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed Box 68760,C& Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy Year Month Day 5 Other (specify) Ö 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐Yes 2 ☐No 1 □Yes Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital 1 Yes 2 XNo Other: $4 \square$ Nursing Home $5 \square$ Residence $6 \square$ Other (Specify) hospice 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar Malcolm

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M. PANSURIPA

31. Date filed (Month, Day, Year)

34-9

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Year 0305 or de Jan 2010 0 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death all Washington Mort N39 ai 0m6 JUMC I If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Birthplace (State or Foreign **Funeral** Year) Months Days Hours 1 □XM 2 □ F Director APRIL 16 1949 WASHINGTON, DC 60 213-82-2844 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f show Department of Health and Mental Hygiene. Important: if items 23a or 28a-f show any injury or other traumatic event, the Modical Examinant out the modified at 1 XYes 2 No Director PRINCE_GEORGE'S MD LEWI SDALE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2007 CHAPMAN ROAD 20783 USA death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 【No Specify. BLACK 2 Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 0 NONE NONE Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental WOODROW STEPHENS MAIDA E. FOSTER ပ 19a. Informant's Name/Relationship (Type, Print) BERNARD RAICHE/GUARIDAN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3313 MEGANS WAY ONLEY, MARYLAND 20832 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MD NATIONAL CEMETERY 2/17/2010 LAUREL, MARYLAND permit. 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 20785 7474 LANDOVER ROAD LANDOVER, MARYLAND 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of respiratory arrest, shock, or heart failure. List only one cause on each Inc. Approximate Interval Between Oilset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of and burial-trar Due to (or as a consequence of) P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 1 ☐Yes 2 ☐No 9 Unknown þ signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 ☐ Yes 2 ☐XNo 1 □Yes 2 **N**No or Attending Physician: director 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 XYes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 03:49 1 🗌 Matural 5 Pending death. Accident investigation 1 Tyes 2 No OKING UN SA within 24 hours after death To the Funeral Director: the 6 Could not be determined 3 ☐ Suicide 28e. Tace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or City or Town, State) filled in by 4 Homicide Tokomin Par MID 209 Hospital Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Compared to the cause of the pasts of examination and/or investigation in my reliable to the cause of the caus Medical 29a. Certifier edical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title 29d. Date signed (Month, Day, Year) rtifie 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month,

DHMH 17 Rev 1/2001

32. Rec

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day MARCH 2010 JOSEPH SMITH 12:15 P M FRANCIS Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 28, 1961 6 Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Funeral Days Min. Hours 1 🔀 M 2 🗆 F Country) Maryland Director 48 May 219-68-7634 Usual Residence of Decedent show Page 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

ant If item 27 is marked other than "natural", or items 23a or 28a-f sho. item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Frederick Maryland Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21701 10 Davis Ave. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☒ No Black, White, etc by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) tree & turf care 12 tree service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Richard C. Smith Sr. Margaret Sayler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Walkersville, MD 21793 Margaret Smith/ mother 67 Main St. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1
Department of I
Important: If it
any injury or o 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) St. Peter's Cemetery 3/9/2010 Libertytown, MD 22. Name and Address of Facility Hartzler Funeral Home 21. Signal of Funeral Service Lice LIbertytown, MD 21762 23a. Part 1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Cancer Onset and Death Physician/ Metastadic una disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence on. that initiated events Due to (or as a consequence of): resulting in death) Last ल्

Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1		23d. Date of delivery Month Day Year
Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I.		use contribute to the cause of death? 2 No 3 Probably 4 Unknown
		24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 26. Place of Death (Co. 1) 1 X Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing	heck only one) Home 5 Residence	6 ☐ Other (Specify)
27. Manner of Death 1 X Natural 5 Pending 2 Accident Investigat		28d. Describe how inju	iry occurred
3 Suicide 6 Could not		28f. Location (Street a City or Town, Stat	nd Number or Rural Route Number, e)

29c. License number

MDD64910

Frederick, MD 21701

29d. Date signed (Month, Day, Year)

-5-2010

DHMH 17 Rev 7/2009

State

Registrar

completed

29b. Signature and title of certifier

Pratima Pander

MAR 08 2010

31. Date filed (Month, Day, Year)

Jackine Bonder

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

400 W 7th St

32, Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For Amend It	ems 24a,23	Marylan Per di	d / Depi Cei	rtificate of	daalth and Death	Mental Hy	giene Reg. No.	2010	05830
	Physic /Medi		1. Decedent's Name (First, Mic	- 1	man				2. Date of De Month January	Day	2010	3. Time of Death 11:30 PM
· Area	Examir		4a. Facility Name (If not instituted Charlestown	Health Cen	ter			sville		I	County of Death	
	Funeral Director		5. Social Security Number 214-50-1835 Usual Residence of Decedent	6. Sex 1 ☐ M 2 💢 F	7. Age (In yrs. 9	**	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		1,5 Year)	9. Birthp 912 Penr	lace (State or Foreign try) isy1vania
	Maryland a-f show iffed at	ctor	10a. State 10b. Coun MD Balt	imore		y, Town or Loc					10	0d. Inside City Limits 1 ☐ Yes 2√ No
	th with the 23a or 28	Funeral Director	10e. Street and Number 709 maiden Ch	oice Lane			10f. Zip Code	1228		_	en of What Coun	try?
9800	within 72 hours after death with the Maryland John. r than "natural", or items 23a or 28a-f show the Medical Examinat must be positived at		11. Marital Status 1 □ Never Married 2 □ Ma 3 ▼ Widowed 4 □ Divorce	Armed Fo 1 ☐ Yes If Yes, Giv	ve e		Vas Decedent of F fYes, specify Cuba □Yes 2 X INo		Specify Yes or No rto Rican, etc.)		4. Race - Americ Black, White, e Specify: Whi	tc.
21215-0036	within iene. • than "	Completed by	15. Decede (Specify only high Elementary/Secondary (0-12) 12	ent's Education lest grade completed) College (1	-4or 5+)	(Give life. L	lent's Usual Occup kind of work done OO NOT use retired ial work	during most of wo d)	orking	16b. Kin	d of Business/Ind	lustry unk
Baltimore, Maryland	2 should be filed vand Mental Hygicand Mental Hygicand Mental Hygicand Mental Hygicand Mental	To Be C	17. Father's Name (First, Middle Calvin Ruth					18. Mother's Na Eller	18. Mother's Name (First, Middle, Maiden Surname) Ellen Haag			
e, Mar	s 1 and 2 should of Health and Mer item 27 is marke other traumatic	V 3	19a. Informant's Name/Relation Carol Ross/c			2344	g Address (Street N. Cata		ta Place	Tucs	son, AZ	85749
timor	e = 10 ge		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☒ Donation 5 ☐ Other (Specify)		emetery, crem	sition (Name of natory or other plac		Date		ocation - City or Town, State	
Bal	permit. Pa Departmer Importanti any injury		21. Sign : ure of Euneral % ryic and a d	1/XMU	MD212	d 655 W. 01						
	Physician /Medical Examiner		23a. Part . Enter the diséase, is shoot or heart failure. List immediate ause (Final disease or condition resulting in death)	a. A	aused the death ach line. All IIIII as a consequ	er O	er the mode of dyir	1.	ac or respiratory a	rrest,		Approximate Interval Between Onset and Death
68760,	tificate be executed ig physician and as the burial-transit	ledical Examiner	Sequentially list conditions, if any, teaching to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	С	or as a consequ							
.O. Box 6	E 01 M	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 morns? 1 □ Yes 2 ☑ No 9 □ Unknown	1 ☐ Live b	come of pregnal irth 2 Fetal ant at time of de own	death 3 🗆	Ectopic pregnanc Other (specify)	у		23	3d. Date of delive Month	ry Day Year
ords, P.	est igne	ğ	Part II. Other significant condit	ions contributing to de		-	derlying cause give	en in Part I.	23e. Did to			e cause of death?
Vital Records,	ilcian: The law r certificate has be ector, page 2 shu	Completed							24a. Was autop perfo 1 ∐Yes	an osy rmed? 2 M No	24b. Were autop prior to con death? 1 ☐ Yes	esy findings available apletion of cause of DNo
Ĭ.	yslcian: is certific director,	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 📉 No	Hospital:	npatient 2 🗆 E	FR/Outnatient	3 DOA Othe		ath <i>(Check only o</i> Home 5 ☐ Resid		Other (Specific	d
Division of	to the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certified completely filled in by the funeral director, to	ation: T	E	28a. Date of (Month)		28b. Time of Injury	28c. Injur Work		28d. Describe t)
Divis	ital or Atto ins after de ral Directo led in by tl	Certification:	4 - Homicide	mined 28e. Place of buildin	g, etc. (Specify	")	et, factory, office		City or Tov	vn, State)	Number or Rural	
	the Hosp nin 24 hou the Funel npletely fil	Medical	one)	ing Physician: To the I Examiner: On the ba and mann	isis of examinat	vledge, death ion and/or inv	occurred at the tir estigation, in my o	ne, date and place pinion, death occ	ce, and due to the curred at the time,	cause(s) a date and p	and manner as st place, and due to	ated. the cause(s)
	vitl con	2	29b. Signature and title of certific	21 16.	14	0	29c. License			29d. Date	signed (Month, E	Day, Year)
			30. Name and address of persor Michael K. Ro	who completed cause	of death (Item		rint)		e. MD 21	/ 228	717 (0_	
	Stat Registra	e	31. Date filed (Month, Day, Year		egistrar's Signat							

States 4848

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0683 Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Jean Spedden 5. 2010 March 1:16 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Stella Maris Hospice Timonium Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Director 220-03-2512 16. 1918 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examinan must be redified at Director 1 ☐ Yes 2 ☑ No Md. Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3 Lough Mask Court Apt. 201 21093 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: \$ Specify 3℃Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Telephone Operator John Hopkins Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be fi ပ Ned Holland Sadie Sterling 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2
Department of Health a
Important: If Item 27 is
any Injury or other Stacey Irrgang/Grand Daughter 2802 Hollingsworth Rd. Reisterstown, Md. 21136 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Mem. Grd. 3/9/10 Timonium, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or compleshock, or heart failure. List only dations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, he cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final NI STAGE **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Dav Year 5 Other (specify) ed by the a signed | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à Physician: The law requires 2 No 1 ☐ Yes 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate perform 2 No 1 □Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one examiner? 2 No Other: 4 Nursing Home 5 Residence 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 6 NOther (Specify) OSPICE Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of D ath 28b. Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after deat Funeral Director: filled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 20 medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2

State

31. Date filed (Month, Day, Registrar

29b. Signature and little of gertifier

32. Registrar's Signature

ress of person who completed cause of death (Item 23a) (Type, Print) 2300

DHMH 17 Rev 1/2001

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 06832 Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Lillian L. Strohminger 2010 March 11:00 a^M /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 8810 Walther Blvd. #3326 Baltimore Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F Months Days Hours 220-09-3138 89 Director 1920 March 11, Maryland Usual Residence of Decedent 10a State 10c. City, Town or Location 10d Inside City Limits "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Director 1 ☐ Yes 2 ☑ No Baltimore Baltimore 10e Street and Number 10f Zin Code 10g. Citizen of What Country? 8810 Walther Blvd. #3326 21234 IISA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 ☐ Yes 2 ▼ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify. Specify: White 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Legal Secretary and Mental Hygi 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Mental permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 is marked t any light yor other traumatic events. Simmons Charles W. Antionette Anuszewski ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1300 York Rd. Ste 110 Lutherville, Md. 21093 Mr. Jeffrey Higdon/ Attorney 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Most Holy Redeemer 3-10-10 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. NamRanckddresowsoff Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ASCUD Vecs /Medical ue to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tra Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 I Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has be irector, page 2 s autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 24 hours after death.

Funeral Director: After this certificately filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 \square Inpatient 2 \square ER/Outpatient 3 \square DOA 1 | Yes 2 | 1 | Yes Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical To the Hosl within 24 ho To the Functional (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) 2010 30. Name and address person who completed cause of death (Item 23a) (Type, Print) State Registrar

Baltimore, Maryland

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 20a b per fh e901 3-8-10 ye State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ MARCH 3 2010^{rea} ELIZABETH **SCHINDLER** Рм 7:00 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death MILFORD MANOR NURSING HOME PIKESVILLE BALTIMORE Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 💢 F Months Days Hours 177677911 220-18-4514 **Director** 99 MD Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho. 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 X Yes 2 □ No MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 124 W. FRANKLIN STREET 21201 USA 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🚺 No
If Yes, Give Black. White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: WHITE Specify: 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ THOMAS ROSENBERGER VIOLA DILL19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JANE SCHINDLER/DAUGHTER 21024 77TH PLACE WEST, #15, EDMONDS, WA Department of Healt Important: If item 2 any injury or other once. 20a. Method of Disposition 20b. Place of Disposition (Name or HEALTO PerSERV TOP) ACORP OAK LAWN CEMETERY Date 20c. Location - City or Town, State ➡ Barlal 2 🕅 Cremation 3 🗆 Removal from State 03/05/2010 4 Donation 5 Other (Specify) BALTIMORE, MD of Fureral Service Lice Sign SOL LEVINSON & BROS., 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or shock, or heart failure. List only or Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) the Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Pregnant at time of death Month Day Year 1 Yes 2 9 Unknown 9 Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an ate has bage 2 s After this certificate funeral director, page performed 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Be 26. Place of Death (Com k only one) မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 28b. Time of 28d. Describe how injury occurred 5 Pending Natural ☐ Accident ☐ Suicide 2 🗌 No Investigation Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after
To the Funeral Direcompleted filled in b Medical 29a. Certifier 1 🕰 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Partioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar 30. Name and address of p

31. Date filed (Month, Day, Year)

n (Item 23a) (Type, Print)

Grane Tree

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ March Edward Thomas Joseph 2010 6:39ат м Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll Hospital Center Westminster Carroll 5. Social Security Numbe . Age (In yrs. last birthday) If Under 1 If Under 24 Hrs. Year 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) MD Months Days 1 □XM 2 □ Jan 1234, Yel 1947 63 **Director** 219-44-8908 Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director MD Carroll Westminster 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 121 Virginia Drive 21158 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? 1 Never Married 2 XMarried Ď Maryland 21215-0036 If Yes, Give Year or Dates Vietnam 1 ☐ Yes 2 ☐ No Specify 3 Widowed 4 Divorced Specify: **Black** Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Truck Driver State Of Maryland e 1 and 2 should be filed wit of Health and Mental Hygie If item 27 is marked other ir other traumatic event, the Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Joseph Lee Thomas Mable Jason permit. Page 1 and 2 should t Department of Health and Me Important: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Stacy N. Thomas (Spouse) 121 Virginia Drive, Westminster, MD 21158 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 💢 Burial 2 🗆 Cremation 3 🗆 Removal from State injury or cemetery, crematory or other place, Fairview Church Cem. 3/8/2010 Taylorsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses HATCHT FUNERALLYHOME & CHAPEL Hai PO Box 195 Sykesville, MD 21784 0 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Ph sician/ disease or condition resulting in death) Medical Due to (or as a consequence Examine Say antially list conditions if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Pregnant at time of death ned by the ar Yes 2 No Unknown g 🗌 Unknown sate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? performed? Yes 2 X No 1 Yes 2 No completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 27 No Hospital မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Mariner of Death Time of Certificate: Date of injury 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending injury 2 Accident
3 Suicide s after death. 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medica 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I 29b. Signature and title of certifie

State Registrar ompleted cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 10a-b, 11, 19b, per Fh 9902 4/6/10 TT State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day Year George Tucker 2:30 PM 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Season's Hospice Randallstown Baltimore If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 3KM 2 F 71 216-36-4395 Director Oct. 13, 1938 Usual Residence of Decedent 10a. State death with the Maryland 10b. County Jefferson 10c. City, Town or Location r than "natural", or items 23a or 28a-f show the Modical Examinar must be notified at 10d. Inside City Limits Director Charlotte Bluemont 1 ☐ Yes 🍇 🗙 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 34165 Ahalt Drive 20135 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: White 2 Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Clerk Retail 12 Pages 1 and 2 should be filed venent of Health and Mental Hygirint: If Item 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Walter Francis Tucker Margaret Mary Conlee 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
34165 Ahalt Drive, Bluemont, VA 20135 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health a
Important: If item 27 is
any injury or other trau Sandra Mary Tucker / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crem. 3/5/2010 Woodbine, MD 21. Signature of Funeral Service Livense), rota Marshall 22. Name and Address of Facility Maryland Cremation Services Maisho PO Box 1413, Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Atherosclerotic Cardiovascular Disease **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Physician/Medical as the attending IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 5 Other (specify) the detached 9 Unknown ģ eg Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ş Q 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe certificate 2 No 1 ☐ Yes 2 □No 1 Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No after death Director: filled in by the 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide thin 24 hours a Hospital 1 Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cal 29a. Certifier completely (Check only one) the To the within ? 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MSRajapakseM.D D0057465 3/3/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, MD. 2120 N.S. Rajapakse, MID. 2835 Smith AV, 19-203, 31. Date filed (Month, Day, Year) 32. Pagistrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM#15perFH, G901, 3/8/2010, WS
State of Maryland / Department of Health and Mental Hygiene [] State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month March Marvin Lee Tonks 2010 46 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frederick Memorial Hospital Frederick Frederick 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth
May 18, 1947 Birthplace (State or Foreign Country) 6. Sex **Funeral** Days Hours Min. 1 🔀 M 2 🗆 F **Director** 62 204-36-3329 Pennsylvania Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important if item 27 is marked other than "nature" any injury or other traumatic page. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director 1 X Yes 2 No <u>Maryland</u> Frederick <u>Frederick</u> 10e. Street and Number 10g. Citizen of What Country? 1506 Andover Lane 21702 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. Completed by 1 Never Married 2 Married 1 X Yes 2 No If Yes, Give 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 Divorced 4 Divorced Year or Dates. 1966-72 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) <u>sales representative</u> publishing co Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည William Tonks Estella Mae Cline 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frances Tonks/ wife 1506 Andover Lane Frederick, MD 21702 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 3/13/2010 Resthaven Mem. Gard. Frederick, MD 21. Signature of Fune all Service Licental 22. Name and Address of Facility Hartzler Funeral Home 11802 Liberty Rd. LIbertytown, MD 21762 23a. Part 1. Enter the disease, or complications that consed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ tobable disease or condition Medical resulting in death) **Examiner** vrhusi Sequentially list conditions, if any, hearing to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner oagul **To the Hospital or Attending Physician**: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Certificate: To Be Completed by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 1 Yes 2 9 Unknown Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 1 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe neral Director: After this certificate filled in by the funeral director, pag 2 🗌 No 1 🗌 Yes Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No Natural 5 Pending Accident Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral I Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier MN D60417 -4-2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 21702 Shah Thomas Whn son 32. Registrar's State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 06837 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death FEBRUARY I, 2010 THOMAS JOSEPH WILLIAM 9:04 P M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death MONTGOMERY TAKOMA PARK WASHINGTON ADVENTIST HOSPITAL | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 10-18-19 28 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1⊠M 2□ F MARYLAND 81 216-24-6125 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1√2 Yes 2 □ No CAPITOL HEIGHTS MD PRINCE GEORGE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20743 U.S.A. 505 SUFFOLK AVENUE 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Army Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Specify: BLACK 1 ☐ Yes 2 🕅 No Specify. 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) GOVERNMENT LANDSCAPE SUPERVISOR 8th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) JOSEPH M. THOMAS JOSEPHINE BOONE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LAWRENCE W. THOMAS/SON 7350 GREEN OAK TERRACE LANHAM, MD 20706 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 □Other Specify) VETERANS CEMETERY: 3/19/10 CHELTENHAM, MARYLAND J. B. JENKINS FUNERAL HOME 21 Signature of Funeral Societ Licensee 22. Name and Address of Facility 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ACUTE MYOCARDIAL disease or condition resulting in death) Due to (or as a consequence of) CORONARY Se ventully list and an if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events) Due to (or as a consequence of): resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? HYPERTENSION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 점 Unknown REWAL INSUFICIENCY 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ♣ No 24a. Was an autopsy performed? Yes 24 No 1 □ Yes 26. Place of Death (Check only one) Hospital: Other: 4 \subseteq Nursing Home 5 \subseteq Residence 6 \subseteq Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Physician /Medical **Examiner** Examiner

Physician

Examiner

Funeral

Director

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P.O.

Division of Vital Records,

or Attending Physician:

25. Was case referred to medical examiner?

1 Yes 2 No 27. Manner of Death

2 Accident 3 ☐ Suicide 4 ☐ Homicide

29a. Certifier

(Check only one)

and manner stated.

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier TOORIG

D40324

29d. Date signed (Month, Day, Year) FEBRUARY 5, 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TERRY JODRIE, MO, FACEP 31. Date filed (Month, Day, Year)

7600 CARROLL AVENUE, 32. Degistrar's Signature

Registrar DHMH 17 Rev 1/2001

State

THROMA PARK, MARYLAND

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #14 per Fh 9901 3/18/10 TT/ #IperPHYS, G901, 3/25/2010, WS State of Maryland / Department of Health and Mental Hygiene

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#17perFH, G901, 3/16/2010, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day Year Harold Philip von Gunten 11:13 AM March 2010 04 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death nes HOSDita BALtimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 6-15-1930 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □M 2 □ F Wash D.C. 79 225-34-1009 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a Maclical Examinar material maintaine. 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore Catonsville Director 1 ☐ Yes 2√2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1319 Westburn Rd. 21228 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: white 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Engineering Elementary/Secondary (0-12) College (1-4or 5+) Electronic Engineer 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Albert von Gunten Diana Smith ပ Jacob 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rose von Gunten-wife 1319 Westburn Rd., Catonsville, MD 21228 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ■ Kurial 2 □ Cremation 3 □ Removal from State Patapsco Cem. 3/10/10 Finksburg, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fletcher Funeral Home 254 E. Main St., Westminster, MD 21157 Komal 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Sep tic days /Medical Due to or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): burial-tran Due to (or as a consequence of) ONGLN TEN HAROLD P.2 Division of Vital Records, P.O. Box 68760 attending physician for use as the buria Physician/Medical 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death rate has been signed by the atte page 2 should be detached for i 3 Ectopic pregnancy in the past 12 months? Month Year 4 Pregnant at time of death Day 2 □No 5 Other (specify) □Yes 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed certificate has been 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed 2 🗹 No 1 □Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director; Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) P FETHI BENRADUANE P22256 March, 04, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BAtlimore

DHMH 17 Rev 1/2001

State

Registrar

BENKADUANE

MAR 08 2010

31. Date filed (Month, Day, Year)

ONGUNTEN

GOO CATON AV

2. Registrar's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 10-01841 State of Maryland / Department of Health and Mental Hygiene Coleatha M. Wilson Certificate of Death 1- For State Reg. No. Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ 1415 hrs **Medical Examiner** March 4, 2010 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Baltimore County** Towson St. Josephs Hospital 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign) Gray If Under 24Hrs. 7, Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number 6. Sex **Funeral** Months Day Hours Min Director and 2 **Y** F 1 M Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location any 10b. County 1 Yes 2 No Ltimora filed within 72 hours after death with the Maryland Director 10g. Citizen of What Country 10f. Zip Code 10e. Street and Numbe 21215 4008 tordleig Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Funeral Was Decedent Ever in U.S. 11. Marital Status Armed Forces? 1 Never Married 2 Married Yes If Yes, Give Year Yes 2 No specify: Widowed Divorced 4 ≥ 16a. Decedent's Usual Occupation (Give kind of work done Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) If item 27 is marked other than 'the redical 2 mit. Pages I and 2 should be filed within partment of Health and Mental Hygiene. portant: If item 27 is marked other th 17. Father's Name (First, Middle, Last) Be Henson 19b. Mailing Address (Street and Num or or Rural Route Number, City or Town, State, Zip Code) ٥ 19a/Informant's Name/Relationship (Type, Print) S Fordleigh 20b. Place of Disposition (Name of cernetery 20a. Method of Disposition Baltimore, crematory or other place) 1 W Burial 2 Cremation 3 4 Donation 5 Other Specify rownsu 22 Name and Address of Facility Signature of Funeral Service Licen artfor a 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line Death /Wedical a. Pulmonary Thromboemboli Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) b. Deep Vein Thromboses Sequentially list conditions, Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last The law requires that the death certificate be executed the attending physician and ed for use as the burial - trar Physician/Medical AMENDED UNPENDED Box 68760 23d. Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year 3 Ectopic pregnancy Live birth Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown Unknown detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I P.0. 1 Yes 2 No 3 Probably 4 Unknown ⋧ Completed Records, 24b. Were autopsy findings available 24a. Was an After this certificate has been funeral director, page 2 should prior to completion of cause of autopsy death? performed? Yes 2 No 1 🗸 Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical of Vital Be Other Nursing Home 5 Residence 6 Other Hospital: 1 Inpatient 2 🗸 ER/Outpatient 3 DOA 1 V Yes 2 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27 Manner of Death Certification: 1 V Natural 1 Yes 2 No Pending

Funeral

filled in by the Director:

Hospital or Attending Physician: ' To the

31 Date filed (Month Day Year) Registrar DHMH 17 Rev 1/2001

Medical

State

30. Name and address of person who completed cause of death (Item 23a)

(Specify)

and manner stated

Assistant Medical Examiner

OCME

32 Registrar's Signatu

Investigation

Could not be

Accident

Suicide

Homicide 29a. Certifier (Check only one)

29b Signature and title of certifier

Carol Allan, MD

ORIGINAL

28e. Place of Injury - At home, farm, street, factory, office building, etc.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 / Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

111 Penn Street, Baltimore, MD 21201

March 5, 2010 O.C.M.E.

29d. Date signed (Month, Day, Year) 29c. License number

28f. Location (Street and Number or Rural Route Number, City

or Town, State)

			For State Registrar	State of Marylan		tment of F			giene Reg. No. 2		0681
			Decedent's Name (First, Middle, La.	st)				2. Date of Dea		10	3. Time of Death
and a	Physici /Medi	cal	Walter Frankl 4a. Facility Name (If not institution, giv	in Weather		b. City Town or	Location of Death	Month 3	Day 7	Year	630pm
,	Examir	iei	FRANKLIN Square		enter		sedale			*	more
	Funeral		5. Social Security Number 6. S	ex 7. Age (In yrs.	last birthday)	f Under 1 Year	If Under 24 Hrs.	8. Date of Birt (Month, Da		9. Birthp	lace (State or Foreig
	Director		231-34-7342 Susual Residence of Decedent	⊠ м 2□ F 78	Yrs.	lonths Days	Hours Min.	12/9/1	931	Virg	ntry) ginia
	yland		10a. State 10b. County	10c. Cit	y, Town or Locat	ion				11	0d. Inside City Limits
	a-fsl	cto	Maryland Baltimo	ore Ess	ex						1 ☐ Yes 2 💢 No
	72 hours after death with the Maryland natural", or items 23a or 28a-f show fisel Examinat must be notified at	Funeral Director	10e. Street and Number		, J.	10f. Zip Code			10g. Citizen of	What Coun	itry?
	th wil	al	1544 Galena Road			21221			U.S.	7\	
	items:	ner	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13. Wa		ispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No-	14. Ra	ce - Americ	
9	after or ite	3	1 ☐ Never Married 2 ☐ Married	1 ∏Yes 2 TYNo				nican, etc.)		ack, White, e	etc.
93	ral",	by	₩Widowed 4 □ Divorced	If Yes, Give Year or Dates:		lYes 2∭ No	Specify:		Speci	^{thy:} Wh	ite
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21	filed within Hygiene. ther than int, the N	Ŝ	8		Assemb	ly Line				obile	
Maryland	be fill sd oth even	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle,	Maiden Surna	me)	
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lar	2 sho and is ma		19a. Informant's Name/Relationship (Type. Print)	19b. Mailing /	Address (Street a	and Number or Ru	ral Route Numbe	er, City or Town	n, State, Zip	Code)
	s 1 and 2 should be filed within 72 hours after di if Health and Mental Hygiene. item 27 is marked other than "natural", or item other traumatic event, the Modical Evaninari		Donald Clinton Me		n) 1544	Galena	Road Es	sex. Ma	rvland	21221	
Baltimore,	a		20a. Method of Disposition 1X Burial 2 □ Cremation 3 □	20b. P	lace of Dispositi emetery, cremat	on (Name of ory or other plac	e)	Date	20c. Location	- City or To	wn, State
Ĕ	Pages nent of I ant: If ite ury or o		4 □ Donation 5 □ Other (Specify	I	ly Hill	Mem Ga	$\frac{3}{1}$	2	Middle	River	, Maryland
alt	permit. Pag Department Important: I any Injury o once.		21. Signature of Funeral Service Licen		22. N	ame and Address	ss of Facility	Gran Children			, ricity reals
Ω	99 E 8 9		Michael C.	Salling Sr.	140	zdzinski 7 Old Ea	i Funeral Astern Av	Home Pi enue E	A ssex. M	arvla	nd 21221
			23a. Part 1. Enter the disease, or com	olications that caused the death						720	Approximate Interval Between
	Physician	W G	shock, or heart failure. List only immediate Cause (Final							4	Onset and Death
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687	ficate phy: s the	gig		.d							
×	certii iding ise ai	Me.	IF FEMALE:	23c. If yes, outcome of pregna	ncv				204 D	-4	
Вох	eath atter for u	iar	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of d	death 3 □ E	ctopic pregnancy	y			ate of delive Ionth	ery Day Year
P.O.	he d / the ched	Physician/Med	1 □Yes 2 □No 9 □ Unknown	9 Unknown	eatii 500	iller (specify)					
σ.	res that the de signed by the be detached		Part II. Other significant conditions of	ontributing to death but not resu	ulting in the unde	riving cause give	en in Part I.	23e, Did to	bacco use cor	ntribute to th	ne cause of death?
of Vital Records,	or Attending Physician. The law requires that the death certificate be executed the death. Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit	Completed by		artery dis	-			1 🗆 Y	es 2DNo	3 □ Prob	pably 4 ☐ Unknow
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Ē	ding f h. After funer	Certification:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury Work		28d. Describe h	ow injury occu	rred	
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.≥	or At fter d irect n by	ŧ۱	4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, street,	factory, office		28f. Location (S City or Tow	treet and Num n, State)	ber or Rura	A Route Number,
	intal direction in the line of interesting in th										
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U	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	one)	and manner stated.							
	0 1 ₹ 1	-	29b. Signature and title of certifier			29c. License			29d. Date sign		uay, Year)
			VVC4 Shiring			RES	50000		3.7.2	010.	
			30. Name and address of person who								
				000 FAANKLIN		re or	Baltimo	re m	d 21	237	
	Sta	to	31. Date filed (Month, Day, Year)	32. Registrar's Signat	ture						

DHMH 17 Rev 1/2001

Registrar

MAR 08 2010

walter

WeatherHolTz

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 27, 2010 11:21 Sarah Ann Werren Pebruary Medical 4a. Facility Name (if not institution, give street and number) or Location of Death 4c. County of Death **Examiner** Hospital Junai Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2**X** F 71 Months Days Hours 04/1/8/1938 015-30-3706 Director MΔ Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location death with the Maryland 10d. Inside City Limits Director PA BEDFORD East St. Claire Township 1 Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 357 Edelweiss Lane 15522 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🎛 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. White Completed by 1 Never Married 2 Married 1 🗆 Yes 2 🖁 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 3 →Widowed 4 □ Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' College (1-4 or 5+) Elementary/Seconday (0-12) the Self Employed Artist Art Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thomas M. Huse Dorothy H. Lynch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anna Marie W. Arnold, Daughter 3101 Storybook Court, Ellicott City, MD 21042 20a. Method of Disposition
1 ☐ Burial 2 🏅 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)
Atlantic Crematory Date 20c. Location - City or Town, State permit. Page 1
Department of I
Important: If it
any injury or or 03/04/2010 Glen Burnie, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Auer Cremation Services of PA 21. Signature of Fund al Service Licensee T. Harman 4100 Jonestown Road, Harrisburg, PA 17109 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final set and Death Physician/ - Colore cha disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or linjury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 Yes 2 the Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? this certificate has autopsy 2/1 No Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital Other: မ 1 🗌 Yes 1 Alapatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide (Month, Day, Year) injury 5 Pending 24 hours after death. Funeral Director: Al 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, filled in by determined building, etc. (Specify) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completed within 2 To the F 29b. Signature and title of certifier 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SINAL HOSPITAL 32. Registrar Signatu State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Charles Wyche	State of Maryland / Department of Health and Mental Hygiene 1- For State Registrar Certificate of Death Reg. No. 2010	6843
Physician/ Medical Examine	1. Decedent's Name (First, Migrole, Last) 2. Date of Death 3. Time (of Death 5 hrs
	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 1301 N. Central Avenue Baltimore	
Funeral Director	5. Social Security Number 6. Sex 7. Age (In ya, last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (Social Security Number 1 Months Days Hours Min. 1-21-40 Foreign Country)	
land f show any once.	MO N-H BALTIMARE	ide City Limits
or death with the Maryland or items 23a or 28a-f show any imust be notified at once. Funeral Director	10e. Sweet and Number 10g. Citizen of What Country? 10f. Zip Code 10g. Citizen of What Country? 10f. Zip Code 10g. Citizen of What Country? 11g. Was Decedent of Hispanic Origin? (Specify Yes or No- 14. Race - American Indian	n Rlack
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36 iin 72 hour han "natu dical Exar pleted	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working ife, DO NOT use retired) Elementary/Secondary (0-12) College (14 or 5+) ANATHON WILLER BAHD, At	<u>'</u>
e, MD 21215-0036 I and 2 should be filed within 7 Health and Mental Hygiene. irem 27 is marked other than r traumatic event, the Medica	B HENKY WYCHO, KANNA WICHE.	AL HOLD
ore, MD s: l and 2 sho of Health and If item 27 is ner traumati	Oa. o of nisposition 20b Place of Disposition (Name of cemetery, Date 20c. Location - Rity or To., S., 1 Burial 2 Cremation 3 Removal from State Company or other plane)	**************************************
Baltimore, permit. Pages I as Department of He Important: If ite Important: If ite injury or other tr	4 Donation 5 Other Sogicity: 7 Figure of Funeral Section List uses 22. Name and others of Facility (Figure of Funeral Section List uses)	THOUGH
Physician /M i J Examiner	failure. List only one cause on each line.	cimate Interval en Onset and Death
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Ox 6876 leath certificate e attending phy for use as the I		Year
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Division of Vital Records, P.O. Ital or Attending Physician: The law requires that th rs after death. Is Director: After this certificate has been signed by led in by the funeral director, page 2 should be detack estrification: To Be Completed by P	24a. Was an autopsy find prior to completion death? 1 Yes 2 No 1 Yes	
Vital F hysician: this certifi I director,	25. Was case referred to medical 26. Place of Death (Check only one) Hospital: The second of the control of th	
ion of Vi ttending Physi teath. tor: After this the funeral di		
Division o Bospital or Attending 24 hours after death. Funeral Director: After tely filled in by the funeral al Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route or Town, State)	Number, City
To the Hos within 24 h. To the Fun completely		
2	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Y February 28, 2010	ear)
	30 Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
State Registrar		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2010 Year **Physician** March MARTE WATSON 7:25 a M LICILLE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Pasadena If Under 24 Hrs. Min. June Drive 7858 Anne Arundel 5. Social Security Number 7. Age (In vrs. last birthday) Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Year) Months 1□M 2ÅF Days **Director** 212-52-4197 61 3,1948 Nov. Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral <u>7858 June Drive</u> 21122 U.S.A 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian Black, White, etc 1 ☐Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 XNc Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify ģ Specify: 3 ☐ Widowed 4 🙀 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "ne any injury or other traumatic event. Ite Intelligence." Elementary/Secondary (0-12) College (1-4or 5+) 12 N/A Factory Worker <u>Nevamar Company</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Robert Kostkowski Julianna 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jill K. Waryu (Daughter-in-law) 1345 Riverwood Way Curtis Bay, Maryland 21226 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Atlantic Cremation 03 '03 '10 Glen Burnie, Maryland 21. Signature of Funeral Service Licensee 22, Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 21122 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ocardial Intarctio **Physician** Immulente /Medical Examiner 1 Fer tenseen Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Box 68760 attending physician Physician/Medical the as IF FEMALE use If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy for Month 5 Other (specify) signed by the a d be detached f P.0. g D Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ð 3 Probably 4 Unknown 1 ☐ Yes Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed Hospital or Attending Physician; The this certificate 2 No 2 No 1 Yes 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home ၉ 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 ☐ Other (Specify) funeral 27. Manne of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 124 hours after death.

le Funeral Director: A pletely filled in by the fu 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only one)

To the 1 within 2 To the 1

State Registrar

31. Date filed (Month, Day-Year)

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

and manner stated.

32. Registrar's Signature **ORIGINAL**

7711 QUE

29c. License number

Rd ste A

29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Vear Month **Physician** 10:10 AM Esther Zaner 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner SEASONS HOSPICE @ NORTHWEST HOSPITAL BALTIMORE **BALTIMORE** If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 11/26/1912 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🛛 F Hours 100-03-4994 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2 No Director BALTIMORE OWINGS MILLS MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 4730 ATRIUM COURT, #105 21117 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 | Yes 2 | No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 No Specify: þ Specify: WHITE 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be KOFNIG MAX KATZ CELIA ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1816 RAMBLING RIDGE LANE #301, BALTIMORE, MD 21209 BYRON ZANER/SON 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State BETH TFILOH CEMETERY ! 3/5/2010 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 120 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Atheroscierotic Cardiovascular Immediate Cause (Final "Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner Due to for sele noneacustion off cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 WUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed: 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Mother (Specify) - Patient Hospital: 1 ☐ Yes 2 ☑ No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide

or Attending Physician: The law requires that the death certificate be executed and Division of Vital Records, P.O. Box 68760, attending physician for use as the buria the has this certificate

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

show

d other than "natural", or items 23a or 28a-f shovevent, its Medical Examinations be notified at

permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygic Important: If item 27 is marked other v any injury or other traumatic event, III

29a Certifier (Check only one)

completely filled in by the funeral after death Director: thin 24 hours a the Funeral I

> State Registrar

M.S.Rujapanse M.D

29b. Signature and title of certifier

29c. License number

1 VCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

DO057465

3/3/10

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2835 Smith AV-5235 - Baltimore, MD 21209 N.S. Rajapakse, M.D.

32. Registrar's Signature

and manner stated.

31. Date filed (Month, Day, Year) MAR 0 5 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2-17-2010 Physician/ Rahman Ahmed 9:36p Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Rockville Shady Grove Hospital If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Funeral 1 **X**M 2 □ F (Month, Day, Country)
India 83 231-96-0835 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d Inside City Limits 72 hours after death with the Maryland Director ms 23a or 28a-f s must be notified Md. Montgomery Rockville 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20854 6 Climbing Rose Ct. USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Examiner Black White etc. 1 Never Married 2 Married 5 Completed by Yes 2x No Maryland 21215-0036 Yes, Give 1 ☐ Yes 2 X No Specify. Asian Specify: "natural", 3 Widowed 4 Divorced Year or Dates Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) other than Elementary/Seconday (0-12) College (1-4 or 5+) the Field Officer World Bank Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental Himportant: If item 27 is marked o any injury or other traumatic evence. marked ည Abdur Rehman Rugaiya Begum 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11208 Long pine trail, Potomac, Md. Atiq R. Ahmed-Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place 1 XBurial 2 Cremation 3 Removal from State George Wash. Cemet. 2-19-10 Adelphi, Md. 4 Donation 5 Other (Specify) Si of Funeral Service Licensee 22. Name and Address of Facility 20011 Universal Mortuary Inc., Wash, D.C. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physicians Sepsis disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Aspiration Pneumonia Sequentially list conditions Examine Due to (or as a consequence of) if any, leading to immediate death certificate be executed Cause (Disease or linjury that initiated events -tran Due to (or as a consequence of): resulting in death) Last burial-Physician/Medical Division of Vital Records, P.O. Box 68760 the attending p for use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Month Year Pregnant at time of death Yes 2 No ed by the a Unknown g Unknown requires that the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Jas autopsy page performed? death? Hospital or Attending Physician; The 1 ☐ Yes 2X No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 Tyes 2 🙀 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 27, Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury work?
1 Yes 2 No 1 🔀 Natural 5 Pending nours after death.

neral Director: At filled in by the fu Μ Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Madel D0067386 2-18-10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sonia John, M.D. 9901 Medical Center Dr., Rockville, Md 31. Date filed (Month 32. Registrar State

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Month}20/2010 Year Physician/ 1415 Willie Bowman, Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Holy Cross Hospital Silver Spring If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign . Age (In yrs. last birthdav) Funeral Days 1 👿 M 2 🗆 F 12/14/1934 Country) 247-52-9880 75 Director Usual Residence of Decedent 23a or 28a-f shov 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State event, the Medical Examiner must be notified at Director Capitol Heights Prince Georges 1 X Yes 2 ☐ No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral USA 20743 7303 Hastings Drive permit. Page 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or itemany injury or other traumair. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 XMarried XYes 2 No Yes, Give Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 XNo Specify: 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Government Supervisor Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ျ Jannie Wilson Willie Bowman, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7303 Hastings Drive Capitol Heights, MD 20743 Alice S. Bowman / wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ABurial 2 Cremation 3 Removal from State Fort Lincoln Cenetery 2/27/2010 Brentwood, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensed 22. Name and Address of Facility Bianchi 814 Upshur ST NW Washington, DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Anoroximate Interval Between Onset and Death Immediate Cause (Final Physician/ Sepsis disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) the attending physician and hed for use as the burial-transit Multiple Myeloma or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Cerebral Vascular Stroke 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Chronic Kidney Disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy autops, performed? Ves 21 No 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: ᅆ 1 ☐ Yes 2 🔀 No 1 XInpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred s after death. work? 1 🗌 Yes 2 🗌 No 1 Natural injury 5 Pending Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined within 24 hours af

To the Funeral Di

completed filled in Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

31. Date filed (Month, Day, Year) State Registrar

29a. Certifier

only one) 29b. Signature and title of certifie

Pothu Raju Nagabhru 1500 Forest Glen Road Silver Spring, MD 20910 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jayanti

🗡 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D0052586

29d. Date signed (Month, Day, Year)

29c License number

10-01680

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2010 06848

E. Deasie	٠,	1-For State Certificate C	of Death	Reg. No.									
Physicia				2. Date of Death Month Day Year February 25, 2010 3. Time of Death 0939 hrs									
al Exami	ner		4b. City, Town, or Location of De										
		Facility Name (if not institution, give street and number) 6105 Sargent Road	Hyattsville	Prince George's									
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24										
Director		239-52-5348 1∑M 2□F 73 Y	Months Days Hours	Min. 05/29/1936 Country) NC									
<u>,</u>		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Loc	ation	, 10d. Inside City Limits									
. ж		loa. otalio		1 Yes 2 X No									
yland a-f sh t once	ctor	MD Prince George's Hyattsv11 10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?									
or 28	Director	6105 Sargent Road	20782	U. S. A.									
permit. Pages 1 and 2 should be fifed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants If liem 27 is marked other than "natural", or items 23a or 28a-f show any Injoury or other traumatic event, the Medical Examiner must be notified at once.	rall		Vas Decedent of Hispanic Origin? Yes, specify Cuban, Mexican, Pu	? (Specify Yes or No- lerto Rican etc.) 14. Race - American Indian, Black, White, etc.									
death or iten must b	Funeral	1 Never Married 2 X Married Armed Forces? 1 Yes 2 X No	Specify: Black										
atter ral", o	J A	3 Widowed 4 Divorced in State 1988	Yes 2 X No specify: ent's Usual Occupation (Give kind										
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d be n lental] arked event,	Be	Sylvester Jefferies Frances Beasley 19a Informant's Name/Relationship (Type, Print) 19b Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)											
shoun and M 7 is m	ြို	Alvernia Beasley 610	138. [110] 110. [12]										
and 2 Fealth item 2 traun			osition (Name of cemetery,	Date 20c. Location - City or Town, State									
ages I		1 X Burial 2 Cremation 3 Removal from State crematory or North La	3-2-2010 Burlington, NC										
partme portal ury or		21. Signature of Funeral Service Licensee 22		Bell and Johnson Funeral Home, P. A.									
E E E	L	23. art 1. Enter the disease or implications that caused the death. Do not enter	5503 Old Branch Ave	., Temple Hills, MD 20748 diac or respiratory arrest, shock, or heart Approximate Interval									
ysician Vedical		Mailure. List only one cause on each line.		Between Onset and Death									
caminer		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	onolism										
		Sequentially list conditions, b	Sequentially list conditions b.										
	Examiner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause											
	Z EX	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):											
The law requires that the death certificate be executed cate has been signed by the attending physician and nage 2 should be deached for use as the burial - transit	<u>2</u>	d		- 1300									
eath certificate be execute attending physician and for use as the burial - trai	Medical	AMENDED 23a,27,28a-f,pe	rmE, g902 4/2/1	0 TT 23d. Date of delivery									
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gned by e detach	Ì	2		1 Yes 2 No 3 Probably 4 Unknown									
w requires that as been signed be should be deta	1			24a. Was an autopsy autopsy 24b. Were autopsy findings available prior to completion of cause of									
e law e has l				performed? death? 1 ✓ Yes 2 No 1 ✓ Yes 2 No									
			26 Place of Death (C										
hysician: The this certificate director, page		on 25. Was case letter to the local examiner? on 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpat		Nursing Home 5 Residence 6 V Other Scene									
After 1		1 2/ Manner of Death 120a, Date of Figure 1	of Injury 28c. Injury at Work?										
death.		Pending Investigation Fd 2/25/10 Fd 9: 28 Pace of Injury - At home, farm, see Pace of Injury - At home, se	25 am										
Hospital or Attend 24 hours after death Funeral Director:	3 1	Suicide 6 Could not be determined (Specify) house		or Town, State) 6105 Sargeant Rd Hyattsville									
Tospit 4 hour 7 uner	>	1 /9d. Utilities Cartellar Develoies To the heet of my knowledge death of	ccurred at the time, date and plac	ce, and due to the cause(s) and manner as stated									
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certif roompletely filled in by the funeral director.	in pier	(Check only one) 2 Medical Examiner: On the basis of examination and/or invessand manner stated 29b Signature and title of certifier	tigation, in my opinion, death occu	urred at the time, date and place, and due to the cause(s)									
F % F S	3	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year) February 26, 2010									
		Mayout MeShill	O.C.M.E.	1 65 daily 20, 2010									
	1	30. Name and address of person who completed cause of death (Item 23a) Margarita Korell MD. Assistant Medical Examiner 11	1 Penn Street, Baltimore,	MD 21201									
		32 Registra's Signature)										
	Sta												

ORIGINAL

DHMH 17 Rev 1/2001 UCME 2000

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Odessa Mae Claytor February 18, 2010 2017 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Prince George's Hospital Center Cheverly Prince George's If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Year) Months Days 1 M 2 X F March 12,1928 244-38-3144 81 North Carolina Usual Residence of Decedent 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location 1XYes 2 No Prince George's Hyattsville Maryland 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code 3508 54th Avenue 20784 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes ≥ 2∑No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Black 1 ☐Yes 2 X No Specify. Specify: 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12th College (1-4or 5+) Housewife Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Carrie Campbell Eddie Purdie 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2707 Webster Street Apt# 3 Mt. Rainer, Md. Douglas E. Hall/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State February 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 27, 2010 Washington, DC Glenwood Cemetery 22. Name and Address of Facility Stewart Funeral Home, Inc. 21. Signature of Funeral Service Lice 4001 Benning Rd. NE Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (o Due to (or as a consequence of) yes, outcome of pregnancy
Live birth 2 Fetal death
Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ANo Day 5 Other (specify) 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐Yes 2 X No 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ANo 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manyfer of Death 28c. Injury at Work? Date of Injury 28b. Time of 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation

Physician /Medical Examiner Examine

physician and is the burial-transit

attending p

has been signed by the e 2 should be detached

certificate ha

funeral director,

After this

death.

n 24 hours after death.

e Funeral Director: A letely filled in by the fu

To the Hosp within 24 hou To the Fune completely fi

Physician/Medical

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Completed

Be

Certification: To

Medical

The law requires that the death certificate be executed

Box 68760,

Division of Vital Records, P.O.

permit. Pages 1
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Important: If itel
any injury or ott

Physician

Examiner

Funeral

Director

ral", or items 23a or 28a-f show Evaminer must be notified at

Pages 1 and 2 should be filed within 72 hours after death with ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or ury or other traumatic event, the Medical Evanture must be

Baltimore, Maryland 21215-0036

Directo

Funeral

Completed by

Be

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the Maryland

/Medical

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE: 23b. Was decedent pregnant

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was case referred to medical examiner? 1 Yes

(Month, Day, Year)

1 ☐Yes 2 ☐ No

3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide

and manner stated

28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29a. Certifier

(Check only one)

29c. License number

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

ess of person who completed cause of death (Item 23a) (Type, Print)

Demetrios Catevenis, M.D. 3001 Hospital Drive Cheverly, Md. 20785

State Registrar 31. Date filed (Month, Day, Year) 2 3 2010

32. Registrar's Signature

		1	For State Registrar				ınd / De	partme	ent of F	. Ensure A Health and N <i>Death</i>	-		2010	0.00	050
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1000	ledica amine		la. Facility Name (If not instit		street and num	ber)		4b. Ci	ty, Town, c	or Location of Death			County of Dea		
			Sacred Heart	Nursi	ing Home	2		Ну	attsv	ille		Pr	ince G	eorge's	
Fun Direc			5. Social Security Number 579–44–5381		x 7]M 2⊠F	. Age (In yi	rs. last birthdi Yrs	Month	der 1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, Di 5/16/	ay, Year)		rthplace <i>(State</i> co <i>untry)</i> rginia	or Foreign
iryland	dat	-	Jsual Residence of Deceden 10a. State 10b. Cor	unty	-	10c.	City, Town or	Location						10d. Inside C	City Limits
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Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show	caminer n	בֿ	11. Marital Status 1 □ Never Married 2□ 3 ☑ Widowed 4□ Divo	Married	12. Was Deced Armed Ford 1 Tes 2 If Yes, Give Year or Dat	es? 2⊠No	U.S.		cedent of I pecify Cub 2 X No	Hispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No o Rican, etc.)	0-	14. Race - Am Black, Wh Specify:		
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of Hyg	ent,	ם ב	17. Father's Name (First, Mic	ldle, Last)						18. Mother's Nam	ne (First, Middle	e, Maiden	Surname)		
rked be	i ii		Walter Bishop							Evelyn C	3.			Una	J.
Shou shou	E I	_	19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State,								Zip Code)				
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Baltimore, permit. Pages 1 ar Department of Hea Important: If item 2	t t		20a. Method of Disposition			20b	Place of Di	sposition (f	Vame of		Date		cation - City o		
Page Pent of	2		1 ☐ Burial 2 X Cremat 4 ☐ Donation 5 ☐ Othe			tate M	etropo			1 2/2/	2/2010	Alex	andria	, Virgi	nia
mit.	in e	1	21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Balti								imore A	venue			
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	-	T	23a. Part1. Enter the diseas shock, or heart failure.	e, or comp	ications that ca	used the de	ath. Do not	enter the n	node of dyi	ng, such as cardiac	or respiratory	arrest,		Approxima Interval Be	ite
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I Records, P.O. Box 687. The law requires that the death certificate ate has been signed by the attending physis	ched for use		IF FEMALE: 23b. Was decedent pregnan in the past 12 mynths? 1 □ Yes 2 ☑ No 9 □ Unknown	t 2		th 2□F int at time o	etal death	3 □Ectopi 5 □ Other		у		2	23d. Date of d Month	elivery Day	Year
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Phys this		2	1 ☐ Yes 2 ☑ No	l .	1 ☐ In 28a. Date o	·	ER/Outpa 28b. Tim		DOA	4 Nursing H	ome 5 Res			pecify)	
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Division or Vital Re Hospital or Attending Physician: The 124 hours after death. e Funeral Director: After this certificate ha	eletely fills					sis of exam				ime, date and place opinion, death occu					(s)

State Registrar

31. Date filed (Month, Day, Year)
FEB 2 3 2010

29b. Signature and title of certifie

Raman Rekha Tuli, 3503 Perry Street, Suite #B, Mount Rainier, MD 20712

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2 AVIS 1720 ARA 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 🗆 M 2 🗷 F Days Min. Hours 871371930 Director 79 Yrs. Washington, DC 579-38-7178 Usual Residence of Decedent 28a-f shov 10b. County within 72 hours after death with the Maryland Examiner must be notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 No MDAnne Arundel Riva 9 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 2792 Cedar Drive 21140 U.S.A. items 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ŏ þ 1 Never Married 2 Married Yes 2 X No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 Divorced "natural" Completed Specify White Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit, Page 1 and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na
any injury or other traumatic event, the Market
once. 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Howard Ennis Alice (unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Smiley W. Davis / Son 2398 Mt. Tabor Road, Gambrills, MD 21054 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Ft. Lincoln Cemetery 2/24/2010 Brentwood, Maryland Signature of Fureral Service License 4739 Baltimore Avenue 22. Name and Address of Facility Gasch's Funeral Home, PA Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ nulmunar disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence or). the Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-tranthat initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Dav 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificate has page 2 autopsy performed 1 Yes 2 funeral director, 25. Was case referred to medical B 26. Place of Death (Check only one) examiner? ၉ 1 Yes 2 No Other: Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred eral Director: After filled in by the funer Natural 5 Pendina work? 1 ☐ Yes 2 ☐ No ☐ Accident Investigation Suicide 6 Could not be 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral D Medical 29a. Certifier Lecritifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

only one)

31. Date filed (Mg

29b. Signature and title of certifier

son who completed cause of death (Item 23a) (Type, Print)

441

ENTAM

Jular

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2010

ANNAPOUS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death FEBRUARY 18 2010 Physician/ 4:10 MELVIN FRANKLIN EDWARDS Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner CENTREVILLE QUEEN ANNE'S QUEEN ANNE'S COUNTY HOSPICE CENTER Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Age (In yrs. last birthday) **Funeral** FEB. 21, Year 1931 Min. 78 MARYLAND **Director** 218-24-7494 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits should be filed within 72 hours after death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at Director MARYLAND QUEEN ANNE'S STEVENSVILLE 1 Yes 2X No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 200 TERRAPIN GROVE APT.317 21666 UNITED STATES 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 X Yes 2 No Black, White, etc. ò 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: WHITE "natural", If Yes, Give 48-1952 Year or 12948-1952 Completed 3 Widowed 4 Divorced event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) YACHT BROKER MARINE Be it. Page 1 and 2 should be filed intment of Health and Mental Hy ortant. If item 27 is marked oth injury or other traumatic even' 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ELIZABETH FORD STEWART EDWARDS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1814 HOFF LANE, FINKSBURG, MD 21048 VALERIE WILLIAMS/DAUGHTER 20a Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of MARNEL AND PARTY OF EXAMPLE) FEB. 22 permit. Page 1 a
Department of IImportant: If ite
any injury or ot 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) CEMETERY - HURLOCK HURLOCK, MD 2010 21. Sign we of Fineral Solvice Licenses FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MD 21619 av ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, line. 23a. Part 1. Enter the disease, or complications that Approximate Interval Between Onset and Death shock, or heart failure. List only one cause or Immediate Cause (Final Physician/ disease or condition resulting in death) Monic obstructive DULMORARY several years Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Cause (Disease or finjury that initiated events resulting in death) Last and the burial-tra Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Dav Year been signed by the a should be detached t g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacgo use contribute to the cause of death? þ disease 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an em bolism has autopsy perform death? this certificate umpho proliferative disease 2 🗌 No 1 Tes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certification completed filled in by the funeral director, to 25. Was cas refe ed t examiner? Certificate: To Be 26. Place of Death (Check only one) 1 🔲 Yes Other: 4 - Nursing Home 5 - Residence 6 X Other (Specify) Fapatient huspice 2 No 1 Inpatient 2 I ER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Daniel Konick 31. Date filed (Month, Day, 32, Registrar's Signature

DHMH 17 Rev 7/2009

Registrar

Kelton Lynwood Foote, Sr.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2

	1- For State Registrar	Certificate of	Death	Reg. N	lo.					
Physician/ Medical Examine	Decedent's Name (First, Middle,Last)			Date of Death Month Day February 8, 2	v Year	3. Time of Death 1020 hrs				
	4a. Facility Name (if not institution, give street and numb Anne Arundel Medical Center	er)	b. City, Town, or Location of Death Annapolis	1	4c. County of Death Anne Arundel					
Funeral Director	216- 70 -5905 1∑M 2□F	Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs Months Days Hours Mir		M/DD/YYYY) 9. Birth Foreign 1954 Comp					
Maryland 28a-f show any d at once. ector	Usual Residence of Decedent 10a. State 10b. County Maryland Queen Anne	10c. City, Town or Locati				10d. Inside City Limits 1 Yes 2 No				
the Maryland Sa or 28a-f sh tiffed at one Director	10e. Street and Number 133 Rustic Acres		10f. Zip Code 21679	10g. C	Citizen of What Count ${ t USA}$	try?				
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Me lival Examiner must be notified at once. To Be Completed by Funeral Director	3 Widowed 4 Divorced If Yes, Give Year or Dates:	es? If Yo 2 X No 1	s Decedent of Hispanic Origin? (Ses, specify Cuban, Mexican, Puerto Yes 2 No specify:	Rican, etc.)	14. Race - Americ White, etc. Specify: B1. 5	ack				
5-0036 ed within 72 hours tygiene. other than "natur the Me iral Exam Completed I	15. Decedent's Education (Specify only highest grade Elementary/Secondary (0-12) College (1-4) 12th 0	or 5+) during me	t's Usual Occupation (Give kind of ost of working life. DO NOT use ret	ired) A	o.Kind of Business/In Anne Arur Dard of I					
1215-0036 The filed within 7 ental Hygiene. arked other than went, the Me is a wen	Charles Foote		Hattie	e (First, Middle, Maide B. Tong	gue					
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Baltimore, permit. Pages I an Department of Her Important: If ite injury or other tr	1 Burial 2 Cremation 3 Removal from 4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	Chews U.	nerplace) .M. Church 2- programme a 限	-20-10 W	West Rive	er, Md.				
Physician	Zarry B, Reese MOSUS 3 23a. Part I. Enter the disease, or complications that cause failure. List only one cause on each line.	a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								
Examiner	or condition resulting in death) Due to (or as a co									
ted Insit Examiner	Sequentially list conditions.	insequence ofy			2:	,				
xecuted 1 and - transit		nsequence or):								
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cords, P.O. Box 68 law requires that the death certif has been signed by the attending 2 should be detached for use as anothered by Physician			inderlying cause given in Part I.	23e. Did tobace	co use contribute to t	the cause of death?				
Division of Vital Records, P.O. Box 687. To the Hospital or Attending Physician: The law requires that the death certification to the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as ledical Certification: To Be Completed by Physician				24a. Was an autopsy performed 1 ✓ Yes 2	prior to co	topsy findings available ompletion of cause of s 2 No				
Vital I sysician: this certifi director,	25. Was case referred to medical examiner? 1 Ves 2 No	atient 2 🗹 ER/Outpatient	26.Place of Death (Check 3 DOA Other Down Nursi	ng Home 5 Res	sidence 6 Other					
Division of Vital Rec To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate completely filled in by the funeral director, page ledical Certification: To Be Con		2010 unk	njury 28c. Injury at Work? 1 X Yes 2 No et, factory, office building, etc.	ceiling		Il while reaching to				
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the		schoo1				ral Route Number, City en Holly Dr				
To the Ho within 24 To the Fu complete!	one) 2 Medical Examiner: On the basis of and manner state 29b. Signature and title of certifier		29c. License number		place, and due to the					
XN<	30. Name and address of person who completed cause Ana Rubio MD. Assistant Medical Ex		O.C.M.E. Street, Baltimore, MD 2120		ebruary 9, 2010	· · · · · · · · · · · · · · · · · · ·				
State	31. Dete filed (Month. Day Year) 32. Reg	strar's Signature								
Registra DHMH 17 Rev 1/2001		ORIGINA	entel							

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

		_ For	Plea: amend	se Type or Pr L #23a Per patte of N	rint in E PHY G9 Maryland	lack Ir 102 4/ 17 Depa	ndelible In l 05/2010 artment of F	k. Ensure A IH Health and M	III Copies Nental Hyg	s Are Leg giene	ible.	
		State Registrar				Cer	tificate of L	Death		Reg. No.2	10	06854
Physicia	an/	1. Decedent's Name		•					2. Date of Dea _Month	Dav	Year	3. Time of Death
Medi	cal			Goldblatt give street and number)	_		4h Oit Terre	Laurian of Dooth	Februa		2010	
Examir	ner	Hillhav	en Nurs	ing Center			Adel	r Location of Death phi		4c. County Prin		George's
Funeral Director		5. Social Security No. 520–16–5	646	6. Sex 7. A	ge (In yrs. las 87	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Pay Dec 18	, Year) , 1922	Cou	hplace (State or Foreign intry) EW York
and show at	'n	Usual Residence of 10a. State	Decedent 10b. County		10c. City,	Town or Loc	cation				10d. Inside City Limits	
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tems	Fune	11. Marital Status	inora b	12. Was Decedent		13. V	Was Decedent of H	ispanic Origin? (Spe	ecify Yes or No-	United		rican Indian,
after d Il", or i xamin	5	1 ☐ Never Marri		If Yes Give] No		f Yes, specify Cuba □ Yes 2 🛣 No	Specify:	Rican, etc.)	Blac Specify:	k, White זגז	h, etc. hite
hours natura ical E	lete	-	15. Decedent		942-4		lent's Usual Occup	ation	Т	16b. Kind of Bu		
nin 72 ne. than "r e Med	Completed	(Spe Elementary/Seco		t grade completed) College (1-4 or	5+)	life. Do	O NOT use retired)	during most of worki	ing			
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be file lental rked c	뎯	Herman		blatt				Etta	Laza		,	
should and M is ma aumat		19a. Informant's Na				19b. Mailin	ng Address (Street a	and Number or Rura	al Route Number	; City or Town, S	tate, Zip	Code)
and 2 Health em 27 ther to		Jonathan 20a. Method of Disp		blatt/son	Jook Di-		Stanford					and 20783
Page 1 nent of I ant: If it			X Cremation	3 ☐ Removal from Stat	e cei	metery, crem	sition (Name of natory or other place ITNEV CTE	e)	Date 23/2010	Woodbi	•	Maryland
perriit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Det artment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at ODS 6.	4 Donation 5 Other (Specify) Final Journey Crematory 2/23/2010 Woodbine, 12 Signature of Funeral Service Licenses M00957 Final Journey Crematory 2/23/2010 Woodbine, 12 Signature of Funeral Service Licenses of Facility Coing Home Cremation Service P.O. Box Beverly L. Heckrotte, P.A. Clarksville											
		23a. Part I. Inter ti	he disease, or o	complications that cause	ed the death.						7 <u>111</u> 6	e, MD 21029 Approximate
hysician/	g Ja	shook, or hear Immediate Cause (I disease or condition	Final	ly one cause on each lin		Heart	e Failur	Θ.				Interval Between Onset and Death
Medical Examiner		resulting in death)	- 1	Due to (or as	s a conseque	nce of):						
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ecuted and I-transit	Examiner	Cause (Disease or in that initiated events resulting in death) L	iinjury		ensive		liovascul	ar Diseas	e		\dashv	25 years
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law requires that the death certificate be executed nas been signed by the attending physician and e 2 should be detached for use as the burial-transit	Physician/Medic	IF FEMALE: 23b. Was decedent in the past 12 n 1 Yes 2 9 Unknown	nonths?	23c. If yes, outcome 1 Live Birth 4 Pregnant 9 Unknown	2 Fetal at time of de	death 3 🗌	Ectopic pregnance Other (specify)	y		23d. Dat		ivery Day Year
requires that the de been signed by the should be detached			icant condition	s contributing to death	but not resul	ting in the u	nderlying cause giv	ven in Part I.	23e. Did to	bacco use contri	bute to	the cause of death?
requires been sign should be	ted b	Cerebro	ovascul	ar Accident				<u> </u>	1 □ Y	′es 2 🔀 No	3 🗌 Pro	obably 4 🗆 Unknown
The law re ate has be page 2 sh	Completed by		d Arter	y Stenosis Aspiration	on Pne	umonia ration	a }		24a. Was a autop perfor 1 Yes	med? p	rior to o leath?	opsy findings available completion of cause of 2 No
ician: sertific ector,	Be	25. Was case referre examiner?		Hospital:			26. Pl	ace of Death (Check	only one)			
Phys r this eral dir	e: To	1 Yes 2 2 27. Manner of Death		1 ☐ Inpa 28a. Date of inj	tient 2 E ury 2	8b. Time of	t 3 DOA	4 LX Nursing Ho		ence 6 Othe		<u>(y)</u>
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To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director. After this certificate is completed filled in by the funeral director, page	Medical	(Check 2	Medical Ex	Physician: To the best o aminer: On the basis of Nurse Practioner: To the	examination a	and/or invest	igation, in my opinic	n, death occurred at	the time, date ar	nd place, and due	to the ca	ause(s) and manner stated.
Norith		29b. Signature and t		Ulm			29c. License D1 78		2	29d. Date signed Februar		
<i>,</i> 41			,	ho completed cause of	,		rint)					
Stat	e.	VIVEK C V 31. Date filed (Month	/ald, M. n, Day, Year)	D. 3311 To				Hyattsvi	lle, Mar	yland 2	0782	>
Registra	ar	31. Date filed (Month	EB 23	2010 Lyun	rar's Signatur	9. 1904	ake		.			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Ivia	ai y aci i		tificate of I			Reg. No	0010	06855	
	Physicia	n/	1. Decedent's Name (First, Middle, Las	t)					2. Date of De		Voor	3. Time of Death	
	Medic		Mary D.	Howland					Februa	ry 1	9, 2010	6:38 ₽ ^M	
	Examin	er	4a. Facility Name (if not institution, give	street and number)				r Location of Deat	th	4c.	County of Deat		
			Casey House 5. Social Security Number 6. Se		0		Ro If Under 1 Year	ckville Tif Under 24 Hrs		Montgomery			
	Funeral Director			M 2XIE	(in yrs. 16 69	ast birthday) Yrs.	Months Days	Hours Min		y, Ye <i>ar)</i> 194	9. Birt Coa	hplace (State or Foreign untry) Maine	
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ctor	10a. State 10b. County		10c. City	y, Town or Lo	cation					10d. Inside City Limits	
	· 28a-	jre	Maryland Montgome	ery		Bet	hesda			1 🗆 Yes 2 🍱			
	th the	je.	10e. Street and Number	_			10f. Zip Code				izen of What Co		
	ith wi	Funeral Director	5302 Glenwood Roa	12. Was Decedent Ev	or in II C	140.1						States	
98	72 hours after death with the Maryland "natural", or items 23a or 28a-f sho ledical Examiner must be notified at	by	11. Marital Status 1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🛣			Vas Decedent of H f Yes, specify Cuba		pecity yes or No- to Rican, etc.)		14. Race - Amer Black, White		
21215-0036	ours a'	Completed	3 Widowed 4 XDivorced 15. Decedent's Ed	If Yes, Give Year or Dates.			Yes 2 X No					White	
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Maryland	uld be filed Mental Hyg narked oth	To Be	17. Father's Name (First, Middle, Last) Mervin Monroe	e Deems				18. Mother's Na Cleta	me (First, Middle, Naylo		Surname)		
Ž	should I and Me is mark aumati		19a. Informant's Name/Relationship (Ty			10h Mailir	g Address (Street	<u> </u>			Town State Zin	Cadal	
	12sh alth ar 27 is rtrau		Susan Howland/dau	, , ,			Glenwood					•	
Ē,	of Heal of Heal of Item 3		20a. Method of Disposition		20b. P	lace of Dispo	sition (Name of		Date		cation - City or		
Ē	Page nent c ant: If ury or		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification 5 ☐		natory or other place rnev Cres	· !	/23/2010	Woo	odbine.	Maryland			
Baltimore,	permit. Page Department o Important: If any injury or once.			1. Signafure of Funeral Service Libertsee Going Home Cremation Service P.O. Beverly L. Heckrotte, P.A. Clarksvi									
		П	23a. Part 1. Enter the disease, or compshool, or heart failure. List only or	lications that caused		n. Do not ente	r the mode of dyin	g, such as cardiad	or respiratory arr	est,	1110 (111	Approximate Interval Between	
and a	hysician/		Immediate Cause (Final disease or condition	a Pancrea	atic	Cance:	r					Onset and Death	
4	Medical Examiner		resulting in death)	Due to (or as a	consequ	ence of):							
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	cate be executed physician and the burial-transit	Examiner	Cause (Disease or iinjury that initiated events resulting in death) Last	c. Due to (or as a	consequ	ence of:							
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8760	ificate ig phys as the	Nedical		d		-							
89	ath certif attending I for use a		Leb. Web debeddin program	23c. If yes, outcome o 1 ☐ Live Birth 2	f pregnar	ncy	l =			Į,	23d. Date of deli	very	
Вох	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	Physician/	in the past 12 months? 1 ☐ Yes 2 🛣 No 9 ☐ Unknown	4 Pregnant at 9 Unknown			Cther (specify)	:у			Month	Day Year	
P.O.	that the ned by detacl		Part II. Other significant conditions co	ntributing to death bu	t not resu	ulting in the u	nderlying cause gi	ven in Part I.	23e. Did to	рвассо и	se contribute to	the cause of death?	
ds,	requires t been sign should be	Completed by							1 🗆 🗎	Yes 2	□ No 3 □ Pr	obably 4 XUnknown	
of Vital Records,	aw rec as be	plei							24a. Was a		24b. Were aut	opsy findings available ompletion of cause of	
Re	The Is	5							perfor	rmed?	death?	2 🗆 No	
tal	sician: The certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:				ace of Death (Che	ck only one)				
ξ	Physi this o	은	1 Yes 2 X No	1 ☐ Inpatier		ER/Outpatien		4 U Nursing F				M Hospice	
0	ing Yffer une	Certificate:	1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day,	Year)	28b. Time of injury	28c. Injury work M 1		28d. Describe h	ow injury	occurred		
Division	al or Attendi s after death il Director; A ed in by the f		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injur building, etc.			et, factory, office		28f. Location (S City or Tow		l Number or Run	al Route Number,	
_	To the Hospital or A within 24 hours after To the Funeral Director Completed filled in by	Medical	(Check 2 Medical Examin	ician: To the best of mer: On the basis of exa e Practioner: To the b	amination	and/or invest	gation, in my opinio	n, death occurred	at the time, date a	nd place,	and due to the c	ause(s) and manner stated.	
	To the comp	4	29b. Signature and title of certifier	7	A.		29c. License				e signed (Month		
			Dunek	when	y c	RNP	RII	5108		Fel	oruary 2	21, 2010	
	8		30. Name and address of person who co	ompleted cause of dea	ath (Item	23a) (Type, P							
			Diane Ruckert 60	01 Muncast			oad Rock	ville, M	aryland	2085	55		
	Stat	е	31. Date filed (Month, Day, Year)	32 Registrar	s Signatu	ire	to Kal						

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ February 2010 Michael Alan Hulley 1445 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Montgomery Silver Spring 1 Year If Under 24 Hrs.
Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 1 🏞 M 2 🗆 F 7. Age (In vrs. last birthdav **Funeral** Country) United Kingdom Months OCT 11, Year) 934 Director 75 216-94-6405 Usual Residence of Decedent 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🙀 No Maryland Montgomery Boyds 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21809 Diller Lane 20841 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by ☐ Yes 2 🛣 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: "natural" 3 Widowed 4 Divorced White Year or Dates d Mental Hygiene. marked other than "natur matic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Engineer Aerospace Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Bernard Hulley Alice Newland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>.s</u> Health tem 27 i Kathleen M. Hulley/wife 21809 Diller Lane Boyds, Maryland 20841 item 2 other 1 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any injury or ot
once. cemetery, crematory or other place) 1 Burial 2 K Cremation 3 Removal from State 4 ☐ Dengtion 5 ☐ Other (Specify) Final Journey Crematory 2/23/2010 Woodbine, Maryland 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, M 21. Sign are of Funeral Service Licens uanita M00957 MD 21029 23a. Part N Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Pnysician/ Follicular Sarcoma disease or condition years Medical resulting in death) Examiner Metastatic Cancer to Lung months Sequentially list conditions, Examiner Due to or as a consequence of If any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events or Attending Physician: The law requires that the death certificate be executed and the burial-tran Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the attending ploched for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Year Pregnant at time of death cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Pneumonia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy this certificate 2 No Yes 2 XNo 1 Yes funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 🔀 No 1 🗌 Yes မ 1 Anpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 24 hours after death.
Funeral Director: After eted filled in by the funer 1 🛛 Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 29b. Signature and title of certifier 29c. License number th D0061887 February 20, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2

State Registrar Silver Spring, Maryland 20910

Ira Rabin, M.D. 1500 Forest Glen Road

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ February 18, 2010 10:00A M Jean Robert Herdt Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Montgomery 5704 Aberdeen Place Bethesda Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 XM 2 D F Months Days Hours Jan 19, 1928 New York Director 214-12-3635 82 Usual Residence of Decedent or 28a-f show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Directo 1 🗌 Yes 2 🔀 No Maryland Montgomery <u>Bethesda</u> 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a 5704 Aberdeen Place 20814 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 XYes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Year or Dates. 1945-47 White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) should be filed within 72 I h and Mental Hygiene. **7 is marked other than "**r College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Radiologist Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Clarence Herdt Elsa Schwenck Ernest 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is Krista E. Herdt/wife 5704 Aberdeen Place Bethesda, Maryland 20814 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State remeter, crematory or other place)
Final Journey Crematory 2/19/2010 1 Burial 2 Cremation 3 Removal from State Woodbine, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licer Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 M00957 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition <u>Meningioma</u>, aggressive variant vears Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and physician and the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 e attending ph d for use as th IF FEMALE: - nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 5 Other (specify) Dav Year 1 Yes 2 L 9 Unknown been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by **Emphysema** Records, 1 \square Yes 2X No 3 \square Probably 4 \square Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s performe death? 1 Yes 2 No Yes 2 X No of Vital funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Yes 2 No 잍 1 Inpatient 2 ER/Outpatient 3 I 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending Division 1 Yes 2 🗌 No upleted filled in by the Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 1 🖾 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 🗌 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1241

Registrar

29b. Signature and title of certifier

31. Date filed (Month FEB 2 3 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Theodore C.M. Li, M.D. 3301 New Mexico Ave, NW Stite 342 Washington, DC 20016

MD14603

29d. Date signed (Month, Day, Year)

February 18, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ P^{M} Stuart Charles Honicker February 2010 9:40 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 49 Dudley Court Bethesda Montgomery Social Security Number If Under 1 Year If Under 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** 1 🕱 M 2 🗆 F Days (Month, Day, Year)
oril 7, 1 Months Hours Director 214-52-3010 1952 57 April Pennsylvania er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Montgomery Bethesda 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 49 Dudley Court 20814 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. Yes 2 No Yes, Give þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify. Specify: Completed 3 Divorced 4 Divorced White 1972-93 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Chief Warrant Officer United States Army 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o Adolph Honicker Jeanne Klein 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shinae Honicker/wife 49 Dudley Court Bethesda, Maryland 20814 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State any injury or Final Journey Crematory 2/23/2010 Woodbine, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee Going Home Cremation Service P.O. Box 784 Homas uanta K M00957 Beverly L. Heckrotte, P.A. Clarksville, MD 23a. Pard. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Hepatocellular Carcinoma Medical Due to (or as a consequence of Examiner Hepatitis C Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of and I-transit that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) anding physician a Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death use 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Day Year 1 Yes 2 9 Unknown signed by the a d be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Hypertension 1 Tes 2 No 3 Probably 4 Unknown cate has been signated by page 2 should by Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Cirrhosis autopsy performed' 2 No Alcohol Abuse Yes 2 No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending Natural nours after death.

neral Director: Aft
filled in by the fur 1 Yes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital within 24 hours To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

15+1

Box 68760

P.O.

of Vital

Division

State Registrar

29b. Signature and title

4900 Georgia Art NW

Washington DC 20307

ress of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Hans Gerard Harrer	ctate of maryland / Bopa	rtment of Health and M tificate of Death	lental Hygiene	10 06859			
Physician/ Medical Examiner			2. Date of Death Month Day Yea February 11, 2010	3. Time of Death 2141 hrs			
	Facility Name (if not institution, give street and number) 6701 Coolridge Road	4b, City, Town, or Loca Temple Hills	ition of Death 4c. County of	4c. County of Death Prince George's			
Funeral Director	5. Social Security Number 577-86-7243 6. Sex 17. Age (In yrs. Ia		Under 24Hrs. 8. Date of Birth(MM/DD/YYYYY Hours Min. 01–06–1956	9. Birthplace (State or Foreign Country)Florida			
and show any ncc.	Usual Residence of Decedent	Town or Location Temple Hills		10d. Inside City Limits 1 XYes 2 No			
the Maryland s or 28a-f sh tiffied at once	10e. Street and Number 6701 Coolridge Rd.	10f. Zip Code 20748	10g. Citizen of Wh US				
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced of Dates: 12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	S. 13. Was Decedent of Hispania If Yes, specify Cuban, Mex 1 Yes 2 X No specify Cuban.	xican, Puerto Rican, etc.) White	- American Indian, Black, o, etc. White			
5-0036 led within 72 hours Hygiene. other than "natur the Medical Exam Completed It	Elementary/Secondary (0-12) College (1-4 or 5+)	16a. Decedent's Usual Occupation (during most of working life. DO Unkno	NOT use retired) DWN Un	known			
1215-C d be filed v lental Hygi arked oth vvent, the J		rer Shi	other's Name (First, Middle, Maiden Surname) irley Matilda Har	rer			
MD 21 nd 2 should alth and Me m 27 is ma "aumatic ev	19a Informant's Name/Relationship (Type, Print) Susan Willis/ Ex Wife 20a. Method of Disposition 20b. P	P.O. Box 1292 Da	Number or Rural Route Number City or Town hlgren, Virginia 224				
imore, Pages I a ment of He tant: If ite or other ti	1 Purial 2 X Cramation 3 Permayal from State	rematory or other place) rerdale Pk Cremato	ory 2-23-10 Riverda	and the second s			
11 20	21 small of Funeral Service Licensee	10583 Middler	acility Ronald Taylor II port Ln. White Plains	, MD 20695			
Physician Medital Examiner	Part I. Enter the disease, or complications the caused the death. failure. List only one cause on each line. Immediate Cause (Final disease a. Multiple Gunshot Wound.)	ds	as cardiac or respiratory arrest, shock, or hea	Approximate Interval Between Onset and Death			
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Unsease or injury that initiated events resulting in death) Due to (or as a consequence of):							
							execu an and al - tra
k 68 1 certi endin use as ciar	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregn 1 Live birth 4 Pregnant at time of dea	2 Fetal death 3 Ed	ctopic pregnancy 23d. Date of Month	delivery Day Year			
cords, P.O. Box law requires that the deatt has been signed by the att 2 should be detached for pleted by Physi	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contributing to 3						
Division of Vital Records, P.O. rat or Attending Physician: The law requires that the start death at Director. After this certificate has been signed by led in by the funeral director, page 2 should be detacertification: To Be Completed by F	25 Was associated to market	20 Direct (FD	autopsy property do 1 1 Yes 2 No 1	/ere autopsy findings available ior to completion of cause of eath? ✓ Yes 2 No			
Vital ysician: his certif director,	25. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 It	ER/Outpatient 3 DOA Other	eath (Check only one) 4 Nursing Home 5 Residence 6	Other: Scene			
ion of Vil tending Physic ath or: After this the funeral dir ation: To	27. Manner of Death 1 Natural 5 Pending Pound: Day, Year)	28b Time of Injury 28c. Injury at V FOUND: 1 Yes 2	Nork? 28d. Describe how injury occurre Subject shot by law enfor				
Division o ospital or Attending hours after death uneral Director: Aft y filted in by the fune Certification:	- Nocident	me, farm, street, factory, office buildin	g, etc. 28f. Location (Street and Number or Town, State) 6701 Coolridge Road, Temp				
Division of ' To the Hospital or Attending Ph within 24 hours after death To the Funeral Director: After t completely filled in by the funeral Medical Certification: T	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination an and manner stated.						
M Me	29b. Signature and title of certifier	29c. License num O.C.M.E.	ber 29d. Date signe February 12	d (Month, Day, Year)			
R 2	30. Name and address of person who completed cause of death (Item 2 Russell Alexander MD. Assistant Medical Exami	23a)		.,			
State Registrar	31 Date filed (Month, Day Year) 32 Registrer's Signatur						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of Maryland / Dep	artment of Health and rtificate of Death		ene 2010	06860			
			Decedent's Name (First, Middle, Last)				3. Time of Death			
Physicia: Medic			Vanessa Trucell Jenkins			17, 2010	0600 A M			
	Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Deat		4c. County of Dea				
			Holy Cross Hospital	Silver Spi	cing	Montgo	merv			
П	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year	8. Date of Birth	9. Bir	tholace (State or Foreign			
	Director		579-72-0292 1 M 2 🖾 F 58 Yrs.	IVIOLITIS Days Hours IVIIII	Oct. 8,	1951	DC DC			
	ld bow tt	_	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Le	ocation			10d. Inside City Limits			
	arylar a-fst fied	cto		Washing	.+		1 ⊠ Yes 2 □ No			
	or 28a notii	Director	DC 10e. Street and Number		g. Citizen of What Co					
	vith th	ra	3451-24th Street SE	10f. Zip Code 20020		United				
	ems r mu	Funeral		Was Decedent of Hispanic Origin? (S		14. Race - Ame				
ဖ	or it	by F	Armed Forces? 1 ☐ Never Married 2 🔀 Married	If Yes, specify Cuban, Mexican, Puer	to Rican, etc.)	Black, White, etc.				
ğ	rs aft iral", Exa	ed	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates.	1 ☐ Yes 2 🖾 No Specify:	Yes 2 X No Specify:		Specify: Afro American			
5-0	hou "natu	plet	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of wo	rking 10	6b. Kind of Business	Industry			
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and and	e filed htal H ed ot ever	To B	17. Father's Name (First, Middle, Last)		me (First, Middle, Ma					
Maryland 21215-0036	uld b d Mer nark natic	-		unknown Christine Smith Ingram						
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e,	and Healt		20a. Method of Disposition 20b. Place of Disp	Kipling Parkway		Dc. Location - City or				
Baltimore,	. O 4- L		1 Burial 2 Cremation 3 Removal from State	matory or other place) Fe	b. 26,					
₹	permit. Page Department Important: I any injury or	1.5					Maryland			
Ba	permit. Departn Importa any inju		MITADELON SE (MMC)	4001 Benning Rd.	tewart Fur NE Washir		20019			
			23a. Part 1 Enter the disease, or complications that caused the death. Do not ent				Approximate			
	Physician	8 36	shock, or heart failure. List only one cause on each line. Immediate Cause (Final				Interval Between Onset and Death			
,	Medical		disease or condition resulting in death) A a. Metastatic Breas Due to (or as a consequence of):	st Cancer			_			
	Examiner									
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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							use contribute to the cause of death?			
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ord	v requ	Set (24a. Was an		utopsy findings available			
autopsy prior to performed?						prior to death?	completion of cause of			
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ō	ng Ph ter th neral		27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred							
on	endir eath. or: Af he fu	fica	2 Accident Investigation	M 1 ☐ Yes 2 ☐ No						
NISI	or Att	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	- At home, farm, street, factory, office Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
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	Hos 24 ho Fune eted 1	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate completed filled in by the funeral director, par	Σ	only one) 3 \square Certifying Nurse Practioner: To the best of my knowledge, 29b. Signature and title of certifier	29c. License number		d. Date signed (Mont				
	->F0		1	D 69916		brony 1	TH, 2010			
2	7		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)		7.0019	. ,			
14	_ /		Nioke Wright 1500 Forest Glen Rd. S:		20910					
	State 31. Date filed (Month, Day, Year) 32. Registre's Signa ure									
	Registra	ar	FEB & 3 2010 Senare D. Again							

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
 Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Dora Kargbo Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince Georges Lanham Doctor's Community Hospital Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 1944 9. Birthplace (State or Foreign Country) **West Africa** . Age (In yrs. last birthday) **Funeral** 1 🗆 M 2 🕱 F Months Days Hours Min. Director 579-31-7008 66 Si<u>erra Leona</u> J<u>anuary</u> Usual Residence of Decedent show 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Prince Georges Lanham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Freetown, Sierra Leone, West Africa 9953 Good Luck Road; Apt. T-1 20706 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: **Black** 'natural" 3 X Widowed 4 Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) uepartment of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic...... Elementary/Seconday (0-12) College (1-4 or 5+) None Housewife Domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Abubakarr Kargbo Jeneba Dumbuya Karabo, 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4406 Hatties Progress Drive; Bowie, Maryland 20720 Kadiatu Ramatu Kamara (Daughter) 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) Date 2010 Freetown, Sierra Leone, 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Wellington Cemetery March 11, West Africa Signature of Funeral Service License 22. Name and Address of Facility R. N. Horton Company Morticians, Inc.; 600 Kennedy Street, N.W.; Washington, D..C. 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ septic disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury Physician: The law requires that the death certificate be executed and for use as the burial-tran that initiated events resulting in death) Last physician Physician/Medical Encephalo. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ___ in the past 12 months? Month ed by the a 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be Division of Vital Records, mellitus Completed 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed death? 2 🗌 No 1 Yes Yes within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, p. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ပ Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 Accident
3 Suicide Investigation 6 Could not be Suicide Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier 1/ Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. the 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) 2120110 7cm 30. Name and address of person who completed cause of death (Item 23a) (Type, Print mD.

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year) FEB 2 3 2010

10-01655 Kourtney Mitchell

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 2010 06862

		- For State Registrar		Cer	tificate of	Death			F	Reg. No.		
Physicia		Decedent's Name (First, Midd	le,Last)						2. Date of Dea		Vone.	3. Time of Death
ical Exami		VOIIDTME'V		MITCHEL	T				Month February	Day 1	/ear	1358 hrs
The state of the s		KOURTNEY 4a. Facility Name (if not institution	on dive street and		<u> </u>	4b. City, Town	, or Location	n of Death			ty of Death	h
		Prince Georges Hosp	· -	mamber)		Cheverly				Prince	George	e's
				<u> </u>	11:0 1: 3	If Under 1		nder 24Hrs.	R Date of B	irth/MM/DD/YY	YY 9 Bir	rthplace (State or
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. la	ast birthday)		Days Hou		1		Foreig	gn
Director		579-49-7997	1 M 2X	F	Yrs		12		NOV.	12, 200)9 ^{Co}	ountry) DC
	ŀ	Usual Residence of Decedent										
any	- I	10a. State 10b. County		10c. City,	Town or Locat	ion						10d Inside City Limits
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Aaryland 28a-f show 1 at once.	ector	DC		WAL	JIIIIOIO	10f. Zip Cod	ie .			10g. Citizen of	What Cou	untry?
Mary d at	မွ	10e. Street and Number										
th the Maryland 23a or 28a-f sho	ä	620 PARKSIDE	PLACE, N	V. E)19				.S.A.	
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5-0036 led within 72 hours afte Hygiene. other than "natural", the Medical Examiner	ā	15. Decedent's Education (Spe	ecify only highest	grade completed)	16a. Deceder	nt's Usual Occ	upation (Giv	ve kind of w	ork done	16b. Kind of	Business	/Industry
hou "nat	eted	Elementary/Secondary (0-12)		je (1-4 or 5+)	during m	nost of working	tife. DO NO	OT use retir	ed)			
36 in 72 han fical	읦	_			N.	Δ				N.	Α.	
5-003 lied within Hygiene d other th	dmo	17. Father's Name (First, Middle	L aet)		11.	11.	18.Moth	ner's Name	(First, Middle	Maiden Surna		
Hyg d out	ပ၂						т.	TEFAN	V N M	TCHELL		
21215-0036 wild be filed within 7 Mental Hygiene. marked other than c event, the Medisa	B		JONES		10h Mailin	a Addross (S				umber, City or T	Town Stat	re Zin Code)
O 2 nould Mid M is m.	유	19a. Informant's Name/Relation								SH., DC		
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland lealth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once		TIFFANY N. MI	ICHELLI									or Town, State
Baltimore, MD 21215 permit. Pages I and 2 should be file Department of Health and Mental H Important: If item 27 is marked o injury or other traumatic event, Il		20a. Method of Disposition	0 D. D.		Place of Dispo		r cemetery,		Date	200. Locati	Jii - City o	1 Town, State
Baltimore, permit. Pages I ar Department of Hes Important: If ite		1 X Burial 2 Crematic		al II OIII State	RMONY M		RK	3-5	-2010	LANDO	VER,	MD
ti Paritmen		4 Donation 5 Other 5 21. Signature of Funeral Service		пи	22.	Name and Add	ress of Fac	ility PT	NCKN Y-			MERAL HOME
3al eermi Sepau mpo		21. Signature of 1 different Service	5 (e) 1	1	52	/ - 8T	H ST.	. N .	E. WAS	SH., DC	2000)2-5236
— 614		Da. Part I. Enter the disease, of	, with	of course the reath								Approximate Interval
Physician		failure. List only one caus	e on each line.	lat cause in a catri	, Do not onto	a 10 1110 do 0. a			, ,			Between Onset and Death
/Medical Examiner	2 10	Immediate Cause (Final diseas		iple inju								- Bodan
LXaiiiiici		or condition resulting in death)	Due to (or	as a consequence of	of):							
		Sequentially list conditions,	b									
	ner	if any, leading to immediate cause. Enter Underlying Cause		as a consequence of	of):							
	min	(Disease or injury that initiated	C. Due to (er	as a consequence of	M:							+
sit.	Еха	events resulting in death) Last	Due to (or	as a consequence o	21).							
executed an and al - transit			– d.		-							
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760, ficate be g physiciatine buria	₹	IF FEMALE:	23c. If v	res, outcome of preg	nancy					23d. Dat Mont	e of delive	ery Day Year
		23b. Was decedent pregnant in past 12 months?		ive birth	44-			opic pregna	ancy	MOIT	11	Day real
Box 68 death certif	<u>:</u>	1 Yes 2 ✓ No 9 U	-t ' 	regnant at time of de	eath 5 C	ther (Specify)						
Records, P.O. Box 68 The law requires that the death certif cate has been signed by the attending page 2 should be detached for use as	Physician		19 0	Inknown		1.17		- D1	220 Dio	tobacco use c	ontribute t	to the cause of death?
i, P.O. Bo ires that the de signed by the I be detached f		Part II. Other significant cond	itions contributi	ing to death but not i	resulting in the	underlying ca	use given ii	iraiti.				robably 4 🗸 Unknown
P.O.	d by	<u></u>							52			
ords, w requir	Completed								24a. Wa	ns an 24 opsy		autopsy findings available ocompletion of cause of
OF law r has b	횰								per	formed?	death?	?
Rec The licate	5							_		s 2 No	1 🗸 `	Yes 2 No
tal Reisian: The certificate	B B	25. Was case referred to medic					Place of De					
Vital hysician: this certifi	Ιo	examiner? 1 ✓ Yes 2 No	Hospital: 1	Inpatient 2	ER/Outpatier	nt 3 DOA	Other	Nursi	ng Home 5	Residence		ier:
n of V ding Ph.	🖫	27. Manner of Death	28a. I	Date of Injury Month, Day, Year)	28b. Time of	Injury 28d	. Injury at W	Vork?	1	e how injury or		
th. : Af	<u>.</u>	1 Natural 5 Pe	nding unl		unk	1	Yes 2	X No	subjec	ct assa	ulted	1
SiOr Attendary death ector:	g		28e	Place of Injury - At I		eet, factory, of	fice building	g, etc.	28f. Location	(Street and N	umber or f	Rural Route Number, City
Division of Vital Records, tal or Attending Physician: The law require and reference and receiver. After this certificate has been sifted in by the funeral director, page 2 should be	\{\frac{1}{2}}		uld not be	ecify) unk	, ,			-	or Town	, State)		
Division of Vital I the Hospital or Attending Physician: hin 24 hours after death. The Funeral Director: After this certifit pipletely filled in by the funeral director,	Certification:	4 X Homicide									nner so ct	tated
Hos 24 h Fun etely		29a Certifier 1 Certifying	Physician: To the	e best of my knowled asis of examination	dge, death occ	urred at the tin	ne, date and vinion, deatl	d place, and h occurred	d due to the ca at the time da	ause(s) and ma ite and place, a	ind due to	the cause(s)
To the within To the complet	Medical	one) 2 Medical Ex	:aminer:On the bi and man	asis of examination ner stated.	and/of investig							
F 3 F 3	🛎	29b Signature and title of cert	fier	00		29c. L	icense num	ber		i	-	Month, Day, Year)
	1	().	- Kr	1001	\sim		D.C.M.E.			Februai	ry 25, 20	010
_	1	30 Name and address of pers	on who completes	cause of death (Ite	m 23a)		_					
		Patricia Aronica-Pol		sistant Medical		111 Pen	n Street.	Baltimo	re, MD 212	201		,
	State		Dener	2. Registra s Signa	acke							
Regi	317:1	1 A A PAI	1									

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

			For State Registrar		State	of Maryla	and / Depa	artmen rtificat			and M	-	giene Reg. No.) 0	06863
	Dhunini		1. Decedent's Name ((First, Middle, Last	1)		-					2. Date of De	ath Day	Year	3. Time of Death
	Physici /Medi		Sidney (Junius	Morto	n						2 –	13 -	2010	
	Examir	ner	4a. Facility Name (If n			imber)				Location of	of Death			inty of Death	
			1610 Ba			7 Ane (In vi	s. last birthday)		an C	I Under:	24 Hrs.	8 Date of Bir		ster	
	Funeral Director		216-56-2 Usual Residence of D	2334	X M 2□F	56	Yrs.	Months		Hours	Min.	8. Date of Bir (Month, Da 9 – 29 -		VA	nplace (State or Foreign untry)
	ow ow			10b. County		10c. (City, Town or Le	ocation							10d. Inside City Limits
	Many 1-1 sh	to	MD V	Wicomic	0	Sa	alisbu	rv							1 XYes 2 No
	hours after death with the Maryland lural', or Items 23a or 28a-f show al Examinar must be notified at	Director	10e. Street and Numb					10f. Zip	Code				10g. Citizen	of What Co	untry?
	23a		7520 Fent	tral Av	e				801				J.S.A.		
	er de	Funeral	11. Marital Status	4 OF Marriad	12. Was Dec Armed Fo 1 ☐ Yes		U.S. 13.	Was Dece If Yes, spe	dent of Hi cify Cuba	spanic Ori n, Mexican	gin? (Spe 1, Puerto	ectfy Yes or No Rican, etc.))- 14. F	Race - Amei Black, White	
36	urs aft	by F	1X Never Married 3 ☐ Widowed 4		If Yes, Gi Year or D	ive		1 🗆 Yes	2 X No	Specify:			Spe	ecity:	le.
21215-0036	d within 72 hours after death with the Marylan jiene. r than "natural", or items 23a or 28a-f show fr han Madical Examiner must be notified at			5. Decedent's Edu onfy highest grad			16a. Dece				4 =4= -4-:		16b. Kind o	Blac f Business/l	
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12	filed w Hygier ther th		12	i 44i-d-1- 1 1			Che	£		40 14-11-		/m²	Resta		t
anc	d fall	Be	17. Father's Name (Fi									(First, Middle		nam <i>e)</i>	
Maryland	shoulk nd Me mark matic	ဥ	Fulton (ype, Print)	-	19b. Maili	ng Address				ne Mor		wn, State, Z	ip Code)
Ž	s 1 end 2 should f Health and Men item 27 ie marke other traumatic		Priscill			ster		25				ebron.		1830	
Je,	of Hex Item		20a. Method of Dispos	sition	-	20b	. Place of Dispo cemetery, cre	sition (Nat	me of			ate	20c. Location		Town, State
Ē	Pages ment of P ant: If its ury or o			Cremation 3 ☐F ☐ Other (Specify)			een A	-		1	-20	-2010	Salis	burv	- MD
Baltimore	permit. Pag Department Important: I iny Injury o		21. Six atura d Fund	mi Syric Linear	2		2:	2. Name ar	nd Addres	s of Facilit	y	eral H			
_	405		23a. Part1. Enter the											ıry,	MD 21801
			snock, or mean i	railure. List only o	lications that in ne cause on	each line.		1			cardiac o	or respiratory a	rrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Fi disease or condition resulting in death)	nal	a	Schre		Lord	non	Jag.	7 h	~			
	Examiner				Due to	(or as a cons	equence of):		(•			,	
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89 X	death certificat e attending phy id for use as th	Physician/Med	IF FEMALE:		23c If yes ou	tcome of preg	inancy						00.4	D-1(-d-1)	
Вох	atten atten I for u	clan	23b. Was decedent p in the past 12 m	onths?	1□Live I	birth 2 ☐ Fe	etal death 3	Ectopic p						Date of deli Month	very Day Year
0	0 60	hysl	1 ☐ Yes 2 ☐ N 9 ☐ Unknown	NO	9□Unkn			3 0 11 10 1 (4)	,,						
٥,	The law requires that the ste has been signed by thi page 2 should be detache	by P	Part II. Other significa	ant conditions co	ntributing to d	leath but not r	esulting in the u	nderlying o	ause give	n in Part I.		23e. Did 1	obacco use c	contribute to	the cause of death?
ğ	v require been sig should b	ed						_				1 🗆	Yes 2□N	o 3∏Pro	obably 4 Unknown
Vital Records,	e taw re has be je 2 shi	Completed										24a. Was		b. Were au	topsy lindings available completion of cause of
		Co											2 No	death?	2 No
Vita	ttending Physician: The Jeath. Lor: After this certificete the funeral director, pag	Be	25. Was case referred examiner?		Hospital:				Othe		of Death	Check only	one)		
of		5	1 ☐ Yes 2 ☐ No. 27. Manner of Death	0	28a. Date		ER/Outpaties 28b. Time of		28c. Injury	4 U NU		me 5 Hesi 28d. Describe			cify)
on	Attending r death. ector: After y the fune	tlor	- /	5 Pending investigation	(Mon	ith, Day Year)	Injury	м	Work	د? Yes 2∐I			,,		
	or Attende efter death Director: I in by the	ll Ce		6 Could not be determined			home, larm, st	reet, lactor	y, office					ımber or Ru	ral Route Number,
۵	tal or A	Certification:	4 - Homicide		build	ing, etc. (Spe	city)					City or To	wn, State)		
	To the Hospital or At within 24 hours effer of To the Funeral Direct completely filled in by	edical	29a. Certifier 1 (Check only 2) one)	Certifying Phy Medical Exami	iner: On the b	e best of my k basis of exami nner stated.	nowledge, deat nation and/or in	h occurred vestigation	at the tim	ne, date an pinion, dea	d place, a th occurr	and due to the ed at the time,	cause(s) and date and place	manner as ce, and due	stated. to the cause(s)
	withi Totl	Σ	29b. Signature and titl	e of certifier	1				c. License		,		29d. Date sig	1	
)	l		1 /W	M		2			454	827	_		2/1	8/10)
0	114	1	30. Name and addres	• 1		se of death (It	em 23a) (Type,	Print)	= 0	RC 50	TITE	ιδ3 ≤	ALISBL	RY M	D 21804
	Sta	te		Day, Year)		Registrar's Sig	nature _	ארטונ	<u>~</u> ,					-	-
	Registi		1	PEB 19 2	2010	Enwa	B. 1	park							

		1 - State Registrar		Ce	rtificate of	Death		Reg. No.	.010	06861
Physici /Medic		Decedent's Name (First, Middle, GEOFFRE			NEWMAN		2. Date of De Month FEBRUA		, 2010	3. Time of Death 9:19 P M
Examin		4a. Facilify Name (If not institution,	give street and number)		4b. City, Town, o	r Location of Dea	th		County of Death	
		816 Quade Str			Охо п Н				Prince G	
uneral			6. Sex 7. Age 1 1	(In yrs. last birthday	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	. (Month, Da	ay, Year)	9. Birthp	olace (State or Foreign ntry)
rector		579-64-4012 Usual Residence of Decedent	X (62 Yrs.			08-05-	1947	Washi	ington, DC
A		10a. State 10b. County	T	10c. City, Town or L	ocation				1	0d. Inside City Limits
f sho	ō	MD Prince	e Georges	Ovon	Hill					1 X Yes 2 □ No
28a- notif	rec	10e. Street and Number		OXOR	10f. Zip Code			10g. Citiz	en of What Cour	ntry?
3a or		816 Quade St.			20745			IJ	.S.A.	
other than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at	Funeral Director	11. Marital Status	12. Was Decedent Ev Armed Forces?	ver in U.S. 13.	Was Decedent of H		Specify Yes or No		4. Race - Americ	
or ite	Ē	1 ☐ Never Married 2 Marrie	ed 1 A Yes 2 No if Yes, Give	G	1 ☐ Yes 2 ☑ No	Specify:	rio Ricari, etc.)		Black, White,	etc.
Fxa	b	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:	ERA	TEL Tes 25X140	Specify.		. '	Specify: Blac	ck
'natu dica	Completed	15. Decedent's (Specify only highest	s Education grade completed)	16a. Dece I (Give	edent's Usual Occup e kind of work done DO NOT use retired	ation during most of we	orking	16b. Kin	d of Business/Inc	dustry
han '	d m	Elementary/Secondary (0-12)	College (1-4or 5+	·)		d)		01-	1.	
her t	ပိ	12th 17. Father's Name (First, Middle, Li	not1	Cust	odi an	19 Matharia Na	ame (First, Middle		urch	
evel evel	Be		•				Feazell		ourrame)	
If item 27 Is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	P	Raymond Newman 19a. Informant's Name/Relationshi		10b Mail	ing Address (Street	and Number or E	Dural Pauta Numl	or City or	Town State 7in	Codol
7 Is me traum			aughter)							(Code)
tem 27 l other tra		Renee Newman (D	augiter)	20b. Place of Disp	osition (Name of	i	Date		ation - City or To	own, State
r H it		1 X Burial 2 ☐ Cremation		Qu antic o	Nat 1 Ce	metery.,			iangle,	
Important: If item 27 any injury or other tr once.		4 □ Donation 5 □ Other (Soc 21. Signa → Of Fun; al Service □		2	2 Name and Addre	ss of Facility	26/2010			
any ir		11/1/2 11	my 12 01		22. Name and Address 447 14th					
7.10	Н	23a. Part1 the disease, or c sho or heart ailure. List o	complications that caused t						DC 200.	Approximate Interval Between
	6 I	sho or heart ailure. List o	only one cause on each line	9.	•	-				Interval Between
sician		Inimi Cause I inai	1						1	Onset and Death
		disease or condit in resulting in deat)		LMONARY A						Onset and Death
edical	П	disease or condil? n resulting in deat)	Due to (or as a		RREST					Onset and Death
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State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature FEB 2 3 2010 Central S. January

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day 19 Anne C. O'Rourke February 2010 9:35 Α Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 7506 Hamilton Spring Road Montgomery Bethesda Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗗 F Hours Min. Director 552-68-9939 63 Nov 9 Missouri 1946 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 Yes 2 No Maryland Montgomery Bethesda 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? 7506 Hamilton Spring Road 20817 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14 Race - American Indian Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 XNo If Yes, Give I and 2 should be filed within 72 hours after of Health and Mental Hygiene.
Item 27 is marked other than "natural", or 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) traumatic event, the Pharmacist Pharmacy Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည George Tianter Elizabeth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Philip O'Rourke/husband 7506 Hamilton Spring Rd Bethesda, Maryland 20817 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or oth once. 1 Durial 2 Cremation 3 Removal from State Final Journey Crematory 2/20/2010 4 ☐ Donation 5 ☐ Other (Specify) Woodbine, Maryland 21. Signature of Funeral Service Licenses Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD homas M00957 nuta MD23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ AMYOTROPHU disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, i.e. ing to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to for as a consequence of attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year 4 Pregnant 9 Unknown 5 Other (specify) Day Pregnant at time of death ed by the a detached f s been signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an cate has page 2 s autopsy performed certificate 2 🗌 No 1 🗌 Yes **Division of Vital** 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital: Other: ပ 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28c. Injury at 28b. Time of 28d. Describe how injury occurred after death. Director: After 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Hospital 24 hours Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 7/2009

State

Barks

N. WOLFE ST.

Rm 248

M.D. NEURIXOGIST

32. Registrar's Signature

REUR

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NICHOLAS J.
31. Date filed (Month, Day, Year)
FEB 23

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 06855 State of Maryland / Department of Health and Mental Hygien ? 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 1:30 PM M Robert Lee Polen February 2010 12 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges Laurel Regional Hospital Laurel 8. Date of Birth Month, Day, Year July 2, 1922 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 7. Age (In yrs. last birthday) Country) Virginia Days Months Hours Min 1**√** M 2□ F 87 Yrs **Director** 577-46-9827 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ₹ No Director Prince Georges Laurel Maryland 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 0 8703 Graystone Lane 20708 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 □Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ∐Yes 2 TyNo ģ Specify: White 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Produce Clerk Safeway Grocery Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit, Pages 1 and 2 should be fi Department of Health and Mental + Important: If item 27 is marked ot any Injury or other traumatic even once. Mental I Collis Grant Polen Sarah Elizabeth Wortman ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Grant G. Polen - Son 26624 Laurel Grove Court, Mechanicsville, Maryland 20659 20b. Place of Disposition (Name of cemetery, crematory or other place)
Union Cemetery 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 02/18/2010 Leesburg, Virginia 22. Name and Address of Facility Fleck Funeral Home, Inc. 21. Signature of Fyneral Service Licensee MO1 254 7601 Sandy Spring Road, Laurel, Maryland 20707 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** 5 hours Cardiac ischemia /Medical Due to (or as a consequence of) Examiner Myocardial infarction 8 hours Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit 10 hours hypotension Due to (or as a consequence of): 24 hours urosensis IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Medical Certification: To Be Completed by atrial fibrillation 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown seizure disorder 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2**√**□ No 1 ☐ Yes 2 🐼 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 LXYes 2 □ No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 D Accident 5 Pending investigation neral Director; / 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours after To the Funeral Dire 29a. Certifier TO Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D37874 February 12, 2010 1001/ se of death (Item 23a) (Type, Print) 30. Name and address of person who completed ca Laurél Regional Hospital, Emerg. Dept., 7300 Van Dusen Road, Laurel, MD 20707 Gerald Apollon, MD 31. Date filed (Month, Day, Year) State we B. parts Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

P.O. Box 68760.

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 = State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ Month February 2010 9:14 LaVerne T. Payne Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 303 Yorknolls Drive Capitol Heights Prince George's If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign . Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) Virginia 1 🗆 M 2 🔼 F Days Months Hours Director 95 Yrs. Aug. 579-16**-**9891 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County 10c. City, Town or Location 10d, Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at. Director 1 X Yes 2 No Capitol Heights Maryland Prince George's 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral United States 20743 303 Yorknolls Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 No Specify 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Government Postal Examiner 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Rebecca Willis Reuben Twyman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 303 Yorknolls Drive Capitol Heights, Md. 20743 Floyd M. Payne/ Husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State February cemetery, crematory or other place) 1

Burial 2

Cremation 3

Removal from State Suitland, Maryland 4 Donation 5 Other (Specify) 23, 2010 Memorial 21. Sign re of Funeral Service Lipensee 22. Name and Address of Facility Stewart Funeral Home, Inc. 4001 Benning Rd. NE Washington, DC 20019 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 20 Years Immediate Cause (Final Physician/ Hypertensive Cardiovascular Disease disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Physician: The law requires that the death certificate be executed for use as the burial-transi and that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 5 Other (specify) ed by the a signed by be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown cate has been sig page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 A No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 🖾 No 욘 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Secretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practicaler: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Re aus D 41240 February 22, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Norman C.Smith, M.D., F.A.C.P. 2905 Mitchellville Rd. # 104 20716 Bowie, MD 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State

Registrar

FEB 2 3 2010

10-01693

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State of Maryland / Department of Health and Mental Hygiene

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cal Exami		William Reib	er						February 2	26, 2010	0006 hrs	
		4a. Facility Name (if not institution, g			4	b. City, Town, o	Location o	f Death		4c. County of De		
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Funeral				(In yrs. last birtl	nday)	If Under 1 Year Months Day			1	l Fo	reign	- 1
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vith th		11. Marital Status	12. Was Decedent	Ever in U.S.		s Decedent of H				- 14. Race - Ar White, et	merican Indian, Blac	:k,
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72 hours after death with the Maryland n "natural", or items 23a or 28a-f sho al Examiner must be notified at once	호	15. Decedent's Education (Specify			Decedent during me	t's Usual Occup- ost of working lif	ation (Give e. DO NOT	kind of w use retir	ork done ed)	16b. Kind of Busine	ssandustry	
6 n 72 h isan "r	Completed	Elementary/Secondary (0-12)	College (1-4 or 5		lect	rical C	ontra	ctor		Const	ruction	
5-0036 led within Hygiene. other than	E	17. Father's Name (First, Middle, La								Maiden Surname)		
15-	Be C	John Francis Re					J۱	une i	Shaughn	essy		
212 212 uld be Ment mark	<u> </u>	19a. Informant's Name/Relationship		19	b. Mailing	Address (Stre	et and Nun	nber or R	Rural Route Nur	nber, City or Town, S	itate, Zip Code)	
MD 21215-0036 0 2 should be filed within 7 th and Mental Hygiene. In 27 is marked other than sumatic event, the Medica		Brenda H. Reiber	/Spouse					ay,		MD 2111		
		20a. Method of Disposition 1 Burial 2 X Cremation	3 Removal from Sta			sition (Name of c her place)	emetery,		Date			
Baltimore, permit. Pages I at Department of Hee Important: If ite		4 Donation 5 Other Spec		Metr		ematory			04/2010	Baltimore	∍, Maryla	nd
altil mit. partm ports ury o		21. Signature of Funeral Service Lic				Name and Addre		יב		neral Home		
		23a. Part I Enter the disease, or co		Hardadh Dog	at aptor t	6512 NW	Crain	n Hw	y . , Bow	ie, MD 20	/ I 5 Approximate	Interval
Physician /Medical		23a. Part I Enter the disease, or co	each line.								Between On Death	nset and
Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Atherosc. Due to (or as a conse		card	<u>liovascu</u>	lar d	isea	ise			
			b.	squerico orj.								
	Jer	Sequentially list conditions, if any, leading to immediate	Due to (or as a conse	equence of):								
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a cons	equence of):								
uted d ansit		events resulting in death) Last	d.								\bot	
60, tte be executed hysician and e burial - transit	sician/Medical	X UNPENDED	AMENDED 23a	27 nem	n F c	901 3/2	4/10	тт				
'60, ate be	₩	IF FEMALE:	23c. If yes, outcome	me of pregnancy	′					23d. Date of de		/ear
687 ertific ding p	ian/	23b. Was decedent pregnant in the past 12 months?	1 Live birth	time of death	-=	etal death (BEctop	ic pregna	ancy	Month	Day Y	Cai
Box 6876 ne death certificate the attending phy hed for use as the	/sic	1 Yes 2 No 9 Unkn	, L		5 <u> </u>	ther (Specify)						
that the d	Phy	Part II. Other significant conditio	ns contributing to deat	h but not resultir	ng in the	underlying caus	e given in P	art I.		obacco use contribu		
, P.O.	ا م						_			es 2 No 3		
ords, w requir s been s	ete								24a, Was auto	psy prio	re autopsy findings a or to completion of ca	available ause of
e law te has	1 =										ath? Yes 2	No
/ital Rec ysician: The l his certificate l director, page	ပိ	25. Was case referred to medical				26.Pla	ce of Death	n (Check	only one)			
Vita ysıcia his cer direct) m	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpati	ent 2 🗸 ER/	Outpatien	nt 3 DOA	Other ₄	Nursi	ng Home 5	J.1661251125 - C	Other:	
of Ing Ph	=	27. Manner of Death	28a. Date of Inj (Month, Day.)		. Time of	Injury 28c. I	njury at Wo		28d. Describe	how injury occurred		
ion tendii eath for: /	atio	1 X Natural 5 Pendir 2 Accident Investi	antion			1	Yes 2		005 1	(Street and Number	or Rural Pouta Num	abor City
Division of Vital Records, plus or Attending Physician: The law requin ours after death After this certificate has been s filled in by the funeral director, page 2 should it	Certification:	3 Suicide 6 Could	not be 28e. Place of I	njury - At home,	farm, stre	eet, factory, offic	e building, (etc.	or Town,		or Rural Route Num	iber, City
£ 6 9 E	Ö	4 Homicide determ	(5,550)			1 - 1 Ab - Aires	date and s	lace on	d due to the da	rep(s) and manner a	s stated	
Fo the Hos within 24 h To the Fur	ig.	(Check only 1 Certifying Phyone) 2 Medical Exam	ysician: To the best of namer:On the basis of exa	ny knowledge, d amination and/or	eatn occi r investiga	ation, in my opin	ion, death o	occurred	at the time, dat	e and place, and due	to the cause(s)	
To t	Medical	29b Signature and title of certifier	and manner stated			29c. Lice	ense numbe	er —		29d. Date signed	(Month, Day, Year)	
	-	1/1/1.	Coll			0.	C.M.E.			February 26,	, 2010	
		30. Name and address of person v	who completed cause of	death (Item 23a	>							
			sistant Medical Ex		11 Pen	n Street, Ba	Itimore, I	MD 21:	201			
	State	31. Date filed (Month, Day, Year) MAR 02	2010 32. Registr	ar's Signature								
Regi	stra	MAK VZ	2010 Chri	wa p		all						
DHMH 17 Rev 1	/2001	OCM	Œ	0	RIGIN	AL						

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Division of Vital Records, P.O. Box 68760	
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			Please	State of Maryland				•		е.
		•	For State Registrar	State of Maryland		ificate of		•	Reg. No. 2	10 06869
	5.		Decedent's Name (First, Middle, Last)					2. Date of De	ath	3. Time of Death
	Physicia Medio		MAUREEN BRECKENR		·			Rebruce Februce	Day Yes	
	Examin	er	4a. Facility Name (if not institution, give st				or Location of Deat	h	4c. County of D	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. Ia	st birthday)	If Under 1 Year				Birthplace (State or Foreign
	Director		212-30-0708	M 2 XF 78	Yrs.	Months Days	Hours Min.	FEB. 1	7, Year) 1931 V	TRGINIA
	and show Lat	or	10a. State 10b. County	10c. City	, Town or Loca	ation				10d. Inside City Limits
	Maryli 28a-f otifiec	Director	MARYLAND QUEEN A	NNE'S CI	HESTER					1 🗆 Yes 2 🔀 No
	th the 3a or t be n	rai D	10e. Street and Number 4005 BRIDGEPOINT	e notwe		10f. Zip Code 2161	0		10g. Citizen of What UNITED	
	e filed within 72 hours after death with the Maryland tal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral		2. Was Decedent Ever in U.S	. 13. W	as Decedent of I	Hispanic Origin? (S	pecify Yes or No-		merican Indian,
36	ifter de ", or it amine	þ	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🖾 No If Yes, Give		Yes, specify Cub □ Yes 2 X No	an, Mexican, Puerl	o Rican, etc.)	Black, W	hite, etc.
ĕ	atural	Completed	3 X Widowed 4 ☐ Divorced 15. Decedent's Edu	Year or Dates.		ent's Usual Occu				WHITE
215	n 72 h s. kan "n Medi	ldmo	(Specify only highest grade Elementary/Seconday (0-12)	completed) College (1-4 or 5+)	(Give kii		during most of wo	rking	16b. Kind of Busine	ss industry
Maryland 21215-0036	d within lygiene. ther tha	ادها	12		HOME	MAKER			OWN HO	ME
ano	uld be filed Mental Hy narked oth	일	17. Father's Name (First, Middle, Last) FRANCIS GIBSON BR	ECKENRIDGE			1	me (First, Middle, JANE BE	Maiden Surname)	
ary	should be filk n and Mental 7 is marked c raumatic eve		19a. Informant's Name/Relationship (Type		19b. Mailing	Address (Street			r, City or Town, State,	Zip Code)
Σ	nd 2 s ealth a m 27 i		ROSS T. ROLOSON/SOI	N .	2513	CECIL D	RIVE, CH	ESTER, M	D 21619	
Baltimore,	permit. Page 1 and 2 should be fi Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ R	emoval from State 20b. Pi		KEY CREMA	TION FE	Date B. 20	20c. Location - City	
ij	nit. Pa artme ortani injury	9	4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funer Service Lice/Isee			ITER Name and Addre	. 2	010		ILLE, MD
ñ	Dep Imp any	Į.	The M.	fella	* FE	LLOWS, 06 SHAMR	HELFENBE OCK ROAD	IN & NEW! . CHESTE!	NAM FUNERA R, MD 2161	L HOME, P.A.
			23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one	cations that caused the death cause on each line.						Approximate Interval Between
	Pnysician/ Medical		Immediate Cause (Final disease or condition resulting in death)		_	PATORY	FAIL	URE		Onset and Death DAYS
	Examiner		resulting in death)	Due to (or as a consequence ACUTE	ence of): RENA	1 [ALLURE			DAYS
		iner	Sequentially list conditions, b. if any, leading to immediate cause. Enter Underlying	Dus to for as a conseque						10/4/5
	cuted and transit	Examiner	Cause (Disease or linjury that initiated events c.	Due to (or as a conseque		CEPHA	LOISAT	14		DAYS
	be executed sician and burial-transit	calE	resulting in death) Last	Due to (or as a conseque	ence oi):					
3760	ficate g phys	/edi	d.							
Division of Vital Records, P.O. Box 6876	h certi tendin r use	an/I	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	c. If yes, outcome of pregnan		Ectopic pregnan	су		23d. Date of	*
. B	e deat the at thed fo	Physician/Medi	1 Yes 2 No 9 Unknown	4 Pregnant at time of deg Unknown	eath 5 🗌	Other (specify) _			Month	Day Year
P.0	that th	by Ph	Part II. Other significant conditions cont	ributing to death but not resu	Ilting in the un	derlying cause g	iven in Part I.	23e. Did to	bacco use contribute	to the cause of death?
ds,	quires en sign	ted t	LUPUS					1 🗆 '	Yes 2□No 3□	Probably 4 Unknown
Š	law re as be 2 sho	Completed						24a. Was autop	osy prior	autopsy findings available to completion of cause of
8	r: The icate h		25. Was case referred to medical					1 🗌 Yes	rmed? death 2 No 1	Yes 2 No
/ita	rsiciar s certif	To Be	examiner?	spital:	B/Outpotiont	Oth	lace of Death (Che		, a 🗆 au	7.1
of	ng Phy ter this neral o		27. Manner of Death 1 ■ Natural 5 □ Pending		28b. Time of injury	28c. Injur	ry at		lence 6 Other (Sp ow injury occurred	респу)
ion	tendir death. tor: Af the fu	Certificate:	1 Atural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be			M 1 🗆	Yes 2 No			
NIS	I or Attending Physician: The la after death. Director: After this certificate ha I in by the funeral director, page	Cert	4 Homicide determined	28e. Place of Injury - At hon building, etc. (Specify)		t, factory, office		28f. Location (S City or Tow	treet and Number or n, State)	Rural Route Number,
	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. with 24 hours after death. completed filled in by the funeral director, page 2 should be detached for use as the	edical		ian: To the best of my knowle						
	the H hin 24 the Fu nplete	Σ	only one) 3 Certifying Nurse	r: On the basis of examination Practioner: To the best of my		ath occurred at the	ne time, date and pla	ace, and due to the	e cause(s) and manner	as stated.
_	Viit To		29b. Signature and title of certifier **Rawush**	/ MIN		29c. Licens	6441	1	29d. Date signed (Mo	
	10/5		30. Name and address of person who con		23a) (Tvpe. Pri		0441		FEBRUARY	
	711		KOLLI, RAMESH	2195 WA	SHING	TON ST	YUET, E	ASTON,	MD 216	01
	Stat Registra	e ar	31. Date filed (Month Day Year) 8 20	32 Registrar's Signatu	. pa	N/s				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) Month Physician /Medical 47 AM Corayman 2010 Saigh Dhango roviust c. County of Death 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death **Examiner** Ba **Baltimore City** The Johns Hopkins Hospital If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 5. Social Security Number Age (In vrs. last birthday) **Funeral** 1 **X** M 2 □ F Hours Director laryland Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location ms 23a or 28a-f show must be notified at 1 XYes 2 □ No Directo t more 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 21208 Funeral Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Examiner 1 Never Married 2 Married 1 ☐ Yes 2 No Specify þ 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry ed other than "natu event, the Medical (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First. in and Mental h 19a. Informanț's Name/Relationship (Type. Print) 19b. Mailing Address (Street and N. ber or Rural Route Number, City or Town, State, Zip ode) 20b. Place of Disposition (Name of gemetery, cremetory or other p 20a. Method of Disposition Date 1 Burial 2 Crem 3 = 5 permit. Page Department o Important: If any Injury or Donation unera Approximate Interval Between Onset and Death Part 1. Enter the disease cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest only one cause on each line. shock, or heart failure. L Immediate Cause (Final Necrotizina enteroc disease or condition resulting in death) Due to (or as a consequence of): rematur Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical as IF FEMALE: use 23d Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death Pregnant at time of death 3 🗌 Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) d by the at detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2-No 3 ☐ Probably 4 ☐ Unknown should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy perform 2 🗌 No 25. Was case referred to medical 26. Place of Death (Check only one) director. Be

Physician /Medical Examiner The law requires that the death certificate be executed physician and s the burial-transit

signed by

Pages 1 and 2 should be filed within 72 hours after death

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'natural".

t of Health a

21215-0036

Maryland

Baltimore,

Box 68760,

Division of Vital Records, P.O.

မ Certification:

examiner 1 Yes Hospital 2 No 1 Impatient 2 ER/Outpatient 3 DOA

Other: 4 Nursing Home 6 Other (Specify) 5 Residence

27. Manner of Death 1 Natural 28c. Injury at Work? 28a. Date of Injury 28b. Time of 5 Pending investigation (Month, Day Year) Injury 1 🗌 Yes 2 Accident 3 Suicide 6 Could not be

28d. Describe how injury occurred 2 □ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 - Homicide

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier

29a. Certifier (check only

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month. Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

phani de WIT MD 31. Date filed (Month, Day, Year)

600 North Wolfe St, Baltimore, MD, 21287

State Registrar

completely filled in by the funeral

Medical

After

Director:

24 hours a Hospital

within 2 To the the

or Attending

death.



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 02 18 Day Eloise Arnell Speaks 10:45 a^M 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 4410 Kinmount Road Prince Georges Lanham 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F Months Days Hours Min. 3-10-1945 Country) Washington, D.C Director 64 227-60-1328 Usual Residence of Decedent 28a-f shov 10a. State ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 ☐ No Prince Georges Lanham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4410 Kinmount Road 20706 United States 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 should be filed within 72 hours after and Mental Hygiene.
is marked other than "natural", 1 Yes 2 No Specify: Specify: Completed 3 Widowed 4 Divorced Year or Dates **Black** permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natuu any injury or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) <u>Adminstrative</u> Federal Government <u>Assistant</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 John Hughes Ione Edwards 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Albert Speaks/ Husband 4410 Kinmount Rd. Lanham, M.D. 20706 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, M.D. Fort Lincoln Cemetery 2/27/2010 Signature of Funeral So 22. Name and Address of Facility Fort Lincoln Funeral Home ice Licensee 3401 Bladensburg Rd. Brentwood, M.D. 20722 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or he at 15 flure. List only one cause on each line. Interval Between Immediate Cause (Final set and Death or ely amo Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to (or do a consequence oi). cause. Enter Underlying Cause (Disease or linjury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Year Pregnant at time of death been signed by the sahould be detached a Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 performed' 1000 this certificate 2 🗆 No Yes 2 No 1 🔲 Yes 25. Was case referred to medical director Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 40 Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending nours after death.

neral Director: Aff
I filled in by the fur 2 Accident
3 Suicide
4 Homicide М Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined in 24 hour,
in 24 hour,
in 26 hour,
completed filler Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 7/2009

5

State

31. Date filed (Mor

P.O. Box 68760

Records,

Division of Vital

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Register's Sign

2000

20706

			_ FOI	epartment of Health and N Certificate of Death		iene _{eg. No} 2010	06872
			1. Decedent's Name (First, Middle, Last)		2. Date of Deat Month	h Day Year	3. Time of Death
	Physici /Medio		Alciva V. Solis		02	20 0010	1445 M
200	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	1
- 5			Mentagerey General Hospital	Olney		Mortgomer	/-
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birth	Months Days Hours Min.	8. Date of Birth (Month, Day,	Voor Cor	place (State or Foreign intry)
	Director		219-25-8625	rs.	12/23/	1917 Bol	ivia
	and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	or Location			10d. Inside City Limits
	//anyl	5	mo Mi				1⊠Yes 2□No
	the N	rect	10e. Street and Number	10f. Zip Code	1	Og. Citizen of What Cou	untry?
	with ta or	Ö	2001	20832		1. SA	•
	eath	Funeral Director	O T T T T T T T T T T T T T T T T T T T		ecify Yes or No-	14. Race · Amer	ican Indian,
	fter d r iten iner	F	11. Marital Status 12. Was Decedent Ever in U.S. Armech forces? 1 □ Never Married 2 □ Married 1 □ Ves 2 2 1 No	 Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto 	Ricán, etc.)	Black, White	, etc.
036	ali, o	5	3 Widowed 4 □ Divorced If Yes, Give Year or Dates:	M☐Yes 2 ☐ No Specify:		Specify:His	panic
215-0036	72 hours after death with the Maryland natural", or items 23a or 28a-f show dreal Exacting must be notified at	Completed	15. Decedent's Education 16a.	Decedent's Usual Occupation	ina	16b. Kind of Business/l	ndustry
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21	filed within Hygiene. other than '	9	4 H	omemaker		Home	
pu	be file	Be (17. Father's Name (First, Middle, Last)	18. Mother's Nam			
Maryland	Mel Mel arke	၉	Carlos Philips	Adria	na Muri	el	
a	2 sho and is ma			Mailing Address (Street and Number or Ru			
	1 and Health em 27 Ither tr			31 Mt.Olney Lane			20832
ore	es 1 of H if iter		20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State	, crematory or other place)		20c. Location - City or T	
<u>Ē</u>	Pa ant Iry		4 Donation 5 Other (Specify)	AWN Cemet. 2-23	3-10	Rockville	,Md.
Baltimore,	permit. Pages 1 a Department of Hee Important: If item any injury or othe		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Universal Mortua	ary Inc	.,Wash,D.	C. 20011
			23a. Part 1. Enter the disease, or complications that seed the death. Do n	ot enter the mode of dying, such as cardiac	or respiratory arr	est,	Approximate Interval Between
4	Physician		shock, or heart fallure. List only one cause on each line. Immediate Cause (Final	Contar ACCIDENT			Onset and Death
	/Medical		disease or condition resulting in death) a. Due to (or as a consequence of the content of the	CULATION			a weeps
	Examiner		ATRIAL F	IBRILLATION			Veurs
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	outed d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events				
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8760,	death certificate be executed e attending physician and of for use as the burial-transit	lical	d				
9	tifica ig ph as th	ledi					
Вох	leath certifica attending ph for use as th	Physician/Mec	IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death	3 ☐ Ectopic pregnancy		23d. Date of deli	•
	deat e atto	icia	1 Ves 24 No. 4 Pregnant at time of death	5 Other (specify)		Month	Day Year
P.0	at the de by the tached	hys	9 ☐ Unknown				
	The law requires that the ate has been signed by th page 2 should be detache	by P	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.	23e. Did to	bacco use contribute to	the cause of death?
Ë	quire en sig				1 □ Y	es 2.⊡Mo 3.⊟Pr	obably 4 🗌 Unknown
Vital Records,	aw requires been so should	Completed			24a. Was a	n 24b. Were au	topsy findings available
Ä	The law te has age 2 :	E O		·	autops perfor	med?∕ death? 2.12No 1 □Yes	completion of cause of
ta	ician: The certificate h rector, page	Be C	25. Was case referred to medical	26. Place of Dea	1 ☐ Yes th (Check only or		2 🗆 140
>	or Attending Physician: after death. Director: After this certific in by the funeral director, I	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Out	Other:		ence 6 Other (Spec	cify)
of	g Physer this eral di	ü	27. Manner of Death 28a. Date of Injury 28b. T	ime of 28c. Injury at		ow injury occurred	,/
lon	nding I th. :: After e funer	iti	1 ID Natural 5 □ Pending (Month, Day, Year) In 2 □ Accident investigation	jury Work? M 1 □Yes 2 □No			
Division	I or Attendi after death. Director: A I in by the fu	ifica	3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, far	m, street, factory, office		treet and Number or Ru	ıral Route Number,
ă	al or A s after i Direct	Certification:	4 Homicide determined building, etc. (Specify)		City or Tow	n, siale)	
	To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	Medical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge 2 Medical Examiner: On the basis of examination and manner stated.				
	To the within To the comple	Me	29b. Signature and tiple of certifier	29c. License number	2	29d. Date signed (Month	h, Day, Year)
	-> - ō		Hope Her - IMM	D00:204	14	6100.00	200 2010
7	275		30 Name and address of paragraphs as marked as use of death /llam 2001	Type Print)	1 /	KISKUARY	20,0010
R	_3		30. Name and address of person who completed cause of death (Item 23a) (DLNEY.	FEBRUARY.	2
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature	CHOOK I HILL WK.	1	1111114CH NO	
	Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature FFR 2 3 2010 Level A. Jack				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 201 02 Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death TOKOMA Montgomery 1 Year If Under 24 Hrs. 7. Age (In yrs, last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 2 M 2 D F Months Hours Min. Country) Virginia Director 230-20-5583 85 Usual Residence of Decedent or 28a-f show 10b. County the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1x Yes 2 □ No Prince Georges Colmar Manor 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 3427 40th Place 20722 US items 72 hours after death 11. Marital Status 12. Was Decedent Ever in LLS Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. and 2 should be filed within 72 hours after c Health and Mental Hygiene. Iem 27 is marked other than "natural", or i þ 1 Never Married 2 Married Maryland 21215-0036 Yes Give 1 ☐ Yes 2 X No Specify: Specify: Black 3 X Widowed 4 ☐ Divorced Completed Year or Dates. 1943-45 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) 11 Woodworker Furniture Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Schmidt Verna Carter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 Margaret Schmidt / Daughter Colmar Manor, MD. Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Page 1 s 1 X Burial 2 Cremation 3 Removal from State injury or Fort Lincoln Cemetery 2/27/2010 4 Donation 5 Other (Specify, Brentwood, MD 21. Signature of uneral Ser 22. Name and Address of Facility Fort Lincoln Funeral Home wice 3401 Bladensburg Rd. Brentwood, MD. 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical ue to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine or Attending Physician: The law requires that the death certificate be executed use as the burial-transl that initiated events resulting in death) Last attending physician by Physician/Medical Box 68760 IF FEMALE: es, outcome of pregnancy ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No ξ Pregnant at time of death 5 Other (specify) Month Day Year signed by the a d be detached for P.O. | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed should been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy performed' death? certificate 1 Yes 2 No 1 Yes 2 X No **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 🔀 No Other: မ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) hours after death. Ineral Director: After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28h Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Tyes 2 ☐ Accident 3 ☐ Suicide Investigation 6 Could not be filled in by the 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Hospital 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completed (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2. 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year

32.. Registrar's Signat

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No.2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Doris P. Thomas Feb. 2010 12:45aM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert Manor Healthcare Center Rising Sun Ceci1 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Nov. 30, 1 Birthplace (State or Foreign Country) NC 6. Sex 7. Age (In yrs. last birthday) Days 1 □ M 2**X** F Yrs 215-30-8302 92 1917 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Ceci1 1 ☐ Yes 2X No Director Rising Sun 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 255 Sylmar Rd. 21911 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No If Yes. Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black. White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates: 1 □Yes 2 ▼No ð Specify: White 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) Beautician Salon Owner 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Curtis Gambill Amanda Brooks 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ralph E. Thomas/ Son 45 Horizon Lane Elkton, MD 21921 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rosebank Cemetery 2/24/2010 Rising Sun, MD R.I. Foard Funeral Home, P.A. 21. Signature of Funeral Service Licenses S. Queen St. Rising Sun, MD 21911 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, it any leading to initial date cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 □ Yes_ 8 No 2. [2] No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28d. Describe how injury occurred

Examiner The law requires that the death certificate be executed burial-transi and Box 68760, ttending physician or use as the buria Physician/Medical ior use a signed by the Division of Vital Records, P.O. <u>გ</u> cate has been signated page 2 should b Completed certificate ial or Attending Physician: 's after death.

I Director: After this certificated in by the funeral director, p Physician: Be Certification: To completely filled in by

Funeral

Director

show

ith and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Experient must be notified at

permit. Pages 1 and 2 s
Department of Health an
Important: If item 27 Is
any injury or other trau

Physician /Medical

Examiner

with the Maryland

Pages 1 and 2 should be filed within 72 hours after death

Baltimore, Maryland 21215-0036

5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day, Year)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State) 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

1 Natural 2 ☐ Accident

3 Suicide

29a, Certifier

4 Homicide

(Check only one)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MO 20

32. Registrar's Signa

and manner stated.

within 24 hours a

To the Funeral C Hospital

Medical

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Feb. 2010 Year 18 James R. Tiffin 8:07a M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Union Hospital E1kton Ceci1 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, **Funeral** Months Days Min. 1 □xM 2 □ F Hours 1931 Director 78 Vrs 272-28-2999 OH May Usual Residence of Decedent 28a-f shov 10a. State 10b. County 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 😾 No MD Ceci1 E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 55 Charles St. 21921 USA within 72 hours after death 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14, Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐XNo Specify. Specify: White 3 Divorced 4 Divorced 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, the Me life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Business Owner Athletic Mats Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 William L. Tiffin Lucy M. Ramsthaler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Tiffin/ wife 55 Charles St. Elkton, MD 21921 20a. Method of Disposition
1 ☐ Burial 2 ⚠ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 2/25/2010 e, P.A. 4 Donation 5 Other (Specify) Foard Funeral Home, Rising Sun, MD Name and Address of Facility
•T. Foard and Jones, Inc.
22 West Main St. Newark. DF 19711 21. Signature of Funeral Service License 23a. Part 1. Enter the disease, or complications that caus of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death Immediate Cause (Final Physician/ Medical resulting in death) Examiner Sequentially list conditions, Examiner if any leading to intredicause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last been signed by the attending physician and should be detached for use as the burial-tran Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has page 2 autopsy performe 2 No 1 Yes completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Certificate: To 2 No Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural 5 Pending work? 2 🗌 No Accident Investigation 24 hours after deat Funeral Director: 2 Accident
3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 To the I Certifying/Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10+1VA ohn Mulvey 111 Icton 21921 31. Date filed (Month, Day, Year) 32. Registrar's Signatu FEB 23 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			for State	State of Ma	arylan				and M	1ental Hy	giene	0.1.0	00070
4			Registrar 1. Decedent's Name (First, Middle, L	cotl	_	Cer	tificate of l	Death			Reg. No.	UIU	00010
	Physicia Medic		Gloria Ma	,	s					2. Date of De Month FERMI		Year 2010	3. Time of Death 3:19 A-M
	Examir		4a. Facility Name (if not institution, g	ive street and number)			4b. City, Town, o	r Location o	of Death		7	nty of Death	
	.*		Prince George'				Cheverly				Princ	e Geo	rge's
	Funeral Director		5. Social Security Number 6 579-42-8250	. Sex 7. Age 1 ☐ M 2 🔀 F	76 (In yrs. la	ast birthday) Yrs.	If Under 1 Year Months Days	If Under I	24 Hrs. Min.	8. Date of Bir (Month, Da	th y, Year)	9. Birth	place (State or Foreign Prigton, DC
			Usual Residence of Decedent							July 8	, 1933	1	295011, 20
	rland f sho	후	10a. State 10b. County		10c. Cit	y, Town or Loc	ation						10d. Inside City Limits
	Mary 28a-	Director	DC		Was!	hington	n						1 X Yes 2 No
	ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	aral [10e. Street and Number 2802 Channing S	treet NE			10f. Zip Code 20018				10g. Citizen d		
	death items ner mu	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S		Vas Decedent of H Yes, specify Cuba					ace - Ameri	
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	and 2 s Health sem 27	1		Son)			Monroe S				ngton,		
Baltimore,	Page 1 a nent of H ant: If ite ury or oth	1	20a. Method of Disposition 1 X Burlal 2 ☐ Cremation 3	☐ Removal from State			sition (Name of atory or other plac	:e)	D	ate	20c. Location	n - City or To	own, State
Ħ	permit. Page Department of Important: If any injury or once.	- 10	4 ☐ Donation 5 ☐ Other (Spe 21. Signature of Funeral Service Lice	cify)	Fort	Linco	1n Cemet	ery	2/26	/2010	Brentw	ood,	MD
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	Physician/ Medical	8	Immediate Cause (Final disease or condition resulting in death)	a FATAL	CAX	DIAC	ARRHY	THM1.	A				Onset and Death
	Examiner		resulting in death)	Due to (or as a	consequ	ence of):							
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ž ×	n certi tendin r use a	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome o			Ectopic pregnanc	v			23d. D	ate of deliv	ery
P.O. Box 68	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	in the past 12 months? 1 ☐ Yes 2X No 9 ☐ Unknown	4 ☐ Pregnant at 9 ☐ Unknown			Other (specify)	,	_		N	lonth	Day Year
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ono	anding sath. nr. Afte	licate	1 Natural 5 Pending 2 Accident Investigation	(Month, Day,	Year)	injury	work'	? Yes 2 □ 1	- 1	8d. Describe h	ow injury occui	теа	
DIVISION OF	or Atte	Certificate:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined			ne, farm, stree	et, factory, office		2	8f. Location (Si City or Town		ber or Rural	Route Number,
5	spital nours a neral C		29a. Certifier 1 Certifying Ph	ysician: To the best of m	nv knowle	dge, death oc	cured at the time.	date and pl	ace, and	due to the cau	se/s) and man	ner as state	
	the Ho	Medical	(Check 2 Medical Exart only one) 3 Certifying Nu	niner: On the basis of exa rse Practioner: To the b	amination act of my	and/or investig knowledge, de	gation, in my opinionath occurred at the	n, death occ time, date a	urred at t and place	he time, date ar , and due to the	nd place, and d cause(s) and n	ue to the cau	use(s) and manner stated ated.
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	i de	-	30. Name and address of person who	oomplated -		20 -) (7	106	536			HEBRU	xxy c	21, 2010
R	10		DR MEHDI SATI	THRIAN	3001	Hosi	nt) PITAL D	FIVE		CHEVE	RLY, M	D 2	21, 2610
	State Registra	~	31. Date filed (Month, Day, Year) FEB 2 3 2010	32. Registrar	's Signatu	ake					,		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #1 Sper Phy C914 425/2011 Jin Elisare All Copies Are Legistre amend items 25,26 per doc 8914 4-25-11 vt Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) Celina Mavra **Velasco** 2. Date of Death 3. Time of Death Physician/ Month Day MAYRA CELINA VELASCO Medical  $7:05^{M}$ February 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 3258 Queenstown Rd #103 Mount Rainer Prince George"s 5. Social Security Number Funeral If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🖺 F Days Hours Months Augors Pay, Ygr), 213-61-5811 1971Cabahas El Sal Director 38 Yrs Usual Residence of Decedent show 10a. State 10b. County filed within 72 hours after death with the Maryland Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f MD Prince George's Mount Rainer 1 4 Yes 2 No 5 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 23a Funeral 20712 El Salvador 258 Queenstown Rd # 103 items ; 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces? 0. Black, White, etc. 1 Never Married 2 Married δ Maryland 21215-0036 Yes 2 No Specify: If Yes, Give Year or Dates Salvadorian Specify: White "natural", 3 Divorced 4 Divorced Completed event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry lould be filed within 72 and Mental Hygiene. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Housekeeper Mc'Donald Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Maria del Carmen Velasco Unknown injury or other traumatic should be and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 1511 Vivian PL Silver Spring, MD 20901 Rita Rosevel Velasco (Cousin) Baltimore, 20a. Method of Disposition Date 2018 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State February 4 Donation 5 Other (Specify) San Isidro, Cabanas San Isidro Ignature of Funeral Service Licen 22. Name and Address of Facility Santa Cruz Funerales Latinos, Inc 600 Kennedy St, NW: Washington, DC, 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Cardiopulmonary Arrest disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Recurrent Cervical CA Sequentially list conditions Due to for as a consequence of; cause. Enter Underlying Cause (Disease or iinjury that initiated events Exami the burial-transit and resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical death certificate be Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No ☐ Pregnant ☐ Unknown 5 Other (specify) Month Year Pregnant at time of death Day signed by the a 9 Unknown Hospital or Attending Physician: The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s performed? Yes 2 No certificate 1 ☐ Yes 2 ☐ No **Division of Vital** filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 🗌 Yes 2 🕱 No. Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a, Certifier completed within 2 only one) 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) D68686 February 19, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20902 Frederick David Mind, M.D. 2101 Medical Park Drive Suite 200 Silver Spring, MD 31. Date filed (Month, Day, Year) FEB 2 3 2010 State

DHMH 17 Rev 7/2009

Registrar

FEB

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

	For State Registrar		Cei	tificate of L	Death		Reg. No. 2		0687
ian/	1. Decedent's Name (First, Middle, L	ast)  RENATE ILSE	TUINT	ER		2. Date of Dea Month Februar	Day	Year 2010	3. Time of Death
ical iner	4a. Facility Name (if not institution, g		11 24 2		Location of Death		"	nty of Death	) 1) A
	Frederick Memo	rial Hospital		Freder	rick			ederic	k
1	561-66-5188	. Sex 1 □ M 2 🛛 F 7. Age ( <i>lin yrs</i> .	. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month Day NOV 9	1938	9. Birthp Count	lace (State or Fore try) <b>German</b> y
Į.	Usual Residence of Decedent  10a. State 10b. County	10c. C	City, Town or Lo	cation				1	0d. Inside City Lin
Director	Maryland Freder	ick	Fre	derick					1 🗌 Yes 2 📮
ق	10e. Street and Number			10f. Zip Code		T	10g. Citizen	of What Coun	try?
Funeral	7307 Ridge Road			2170	)2		Gern	nany	
Full	11. Marital Status	12. Was Decedent Ever in U Armed Forces?		Was Decedent of Hi f Yes, specify Cuba	ispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)		Race - Americ Black, White, e	
To Be Completed by Funeral Director	1 Never Married 2 Marrie 3 Widowed 4 XDivorced	d 1 ☐ Yes 2 █ <b>X</b> No If Yes, Give Year or Dates.		1 ☐ Yes 2 🔀 No	Specify:		Spec		
Completed	15. Decedent's	s Education		dent's Usual Occup			16b. Kind o	f Business Inc	dustry
l E	(Specify only highest Elementary/Seconday (0-12)	College (1-4 or 5+)	life. D	kind of work done o O NOT use retired) -				_	
Be C		3	Socia	l Science	***************************************			earch	
년 B	17. Father's Name (First, Middle, Las					ne (First, Middle, i	Maiden Surna	ame)	
	(unk) 19a. Informant's Name/Relationship	Krauss (Type Print)	19h Mailir	ng Address (Street a	( unk		City or Town	State Zin C	'adal
	Richard A. Chris		ide	Ridge Ro			•		
	20a. Method of Disposition	20b.	Place of Dispo	sition (Name of		Date Page		on - City or To	
	1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe			natory or other place rney Cren		22/2010	Woodl	oine. N	Maryland
	21. Signature of Funeral Service Lie								
	Quanta OX	homos MOO!	957 B	Name and Address oing Home everly L.	Heckrot	te, P.A.	Clar	(sville	e, MD 210
/ ! !	show, or heart failure. List onl Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions,	a. Ano Due to (or as a conse	Hhm	en ce	phalo	path	J		Interval Between Onset and Death
dical Examiner	if any, heading to minimize cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	c. Due to (or as a conse							
Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome of pregr 1 ☐ Live Birth 2 ☐ Fe 4 ☐ Pregnant at time or 9 ☐ Unknown	etal death 3	Ectopic pregnand Other (specify)	Sy .		- 1	Date of delive	ery Day Year
þ	Part II. Other significant conditions	s contributing to death but not re	esulting in the u	ınderlying cause giv	ven in Part I.				e cause of death?
Completed						24a. Was a		b. Were autop	osy findings availa
l E						autop perfor	med?	prior to cor death? 1 \(\sum \) Yes	mpletion of cause
Be C	25. Was case referred to medical			26. Pla	ace of Death (Chec		2 No	i Li fes	2 L NO
10 E	examiner? 1  Yes 2 No	Hospital: 1 Inpatient 2	☐ ER/Outpatier	nt 3 🗆 DOA Othe	er: 4  Nursing H	ome 5 🗆 Resid	ence 6 $\square$ C	ther (Specify)	
	27. Manner of Death 1 X Natural 5 □ Pending	28a. Date of injury (Month, Day, Year)	28b. Time of injury	work	?	28d. Describe he	ow injury occ	urred	
Certificate:	2 Accident Investigat 3 Suicide 6 Could no 4 Homicide determine	t be			Yes 2 No	28f. Location (S City or Tow		nber or Rural	Route Number,
Medical	(Check 2 Medical Exa	hysician: To the best of my knowniner: On the basis of examinations of examinations are the best of th	ion and/or invest	tigation, in my opinio	on, death occurred a	at the time, date as	nd place, and	due to the cau	ise(s) and manner s
	29b. Signature and title of certifier	.1		29c. License	number			ned (Month, L	* .
1	3	Ku Na			35106		2/1	1/2	0/6
	30. Name and address of person who Myung Hee N	o completed cause of death (Ite  am 400 v  2010 32 degistrar's Sign	m 23a) (Type, F	rint)		. m a	~ · · · ·	•	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Kenneth Thomas Worsham 2/18/2010 9:07 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 14516 Mayfair Drive Laurel Prince George's 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 🛣 M 2 🗆 F Months Days Hours Min Country) Washington, DC Director Yrs 212-66-5357 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location notified at 10d. Inside City Limits Director 1 X Yes 2 □ No MD Prince George's Laurel ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be items 23a Funeral 14516 Mayfair Drive 20707 U.S.A. death v 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Armed Forces? Black, White, etc. ò þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: Specify: "natural" Completed 3 X Widowed 4 Divorced White Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working aith and Mental Hygiene. 27 is marked other than ir traumatic event, the Me than Elementary/Seconday (0-12) College (1-4 or 5+) the 12 Shipping Receiving Clerk Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Kenneth E. Worsham Mae Josephine Purdy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health a Kenneth E. Worsham/Father 4004 Hamilton Street, Hyattsville, MD 20781 Department of Healt Important: If item 2 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 🔀 Burial 2 🗆 Cremation 3 🔲 Removal from State 4 Donation 5 Other (Specify) Lincoln Cemetery 2/26/2010 Brentwood, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, PA Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) ATheros el ero Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to for as a consequence of,: Cause (Disease or iinjury and the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physiciar Physician/Medical The law requires that the death certificate be as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death nse 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ for in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death Day detached the 9 🗌 Unknown P.O. by s been signed the should be detailed Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 2 No certificate 1 Yes Division of Vital 25. Was case referred to medical Hospital or Attending Physician: Be 26. Place of Death (Check only one) examiner2 Hospital Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at after death. Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending ☐ Yes 2 ☐ No Accident Investigation the Suicide 6 Could not be 3 ☐ Sulciue 4 ☐ Homicide in by t Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) completed fille 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: It the destroit by invested. Certifying Nurse Practioner: To the best of my knowledge. within 7 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0

Registrar

3001

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Vital

of

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 12:25 AM Maria Luisa Arteche March 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Fairfield Nursing Center Crownsville Anne Arundel Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 □ M 2 🗓 F (Month, Day, Year) 05-06-1918 Days Months Hours Min. Director Puerto Rico 075-14-4180 91 Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Iem 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director "natural", or items 23a or 28a-f s edical Examiner must be notified 1 Yes 2X No MD Anne Arundel Odenton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8605 Wandering Fox Trail Unit 307 21113 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give 1 X Yes 2 □ No Specify: 3 Widowed 4 K Divorced Specify: Year or Dates Puerto Rican White and Mental Hygiene.
Is marked other than "natur raumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Bank of New York Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ Bernardo Urbina Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Arteche / Son cortant; If item 2; injury or other t Wandering Fox Trail Unit 307 Odenton, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) W. Arundel Crematory 3-6-2010 Odenton, Maryland 21. Signatur of Funeral Service Livense 22. Name and Address of Facility Donaldson Funeral Home & Crematory, P.A. 1411 Annapolis Road Odenton, Maryland 21113 Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to immediate sician and burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) signed by the attending physician d be detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy 4 Pregnant a Pregnant at time of death 5 Other (specify) Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown To the Funeral Director: After this certificate has been si completed filled in by the funeral director, page 2 should to 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy the Hospital or Attending Physician: The I hin 24 hours after death.

the Funeral Director: After this certificate h performe 2 No Yes 2 X 1 \sum Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 - Residence 6 - Other (Specify) Hospital: ျ 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5  $\square$  Pending **Natural** work 1 Tes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifie 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) 29b. Signature and title of

Registrar
DHMH 17 Rev 7/2009

State

30. Name and address of poson who completed cause Da Rest Scar

31. Date file (Month, Day, Year)

of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - State of Maryland / Department of Health and Mental Hygiene per dr.,g901,03/09/2010dhb Certificate of Death Reg. No. edent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Physician/ Month Day Vear a 10 Februar 30 A Medical 010 4a. Facility Name (if not institution, give street and number Town, or Location of Death Examiner 4b. City 4c. County of Death 8. Date of Birth Birthplace (State or Foreign Country) Funeral 1 🗆 M 2 🔀 Months Hours Month Bay, Yo Director Yrs. show 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1timore 1 Yes 2 No 40 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral alce 1212 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Armed Forces Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working DO NOT use retired) conday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, La. Mother's Name (First, Middle, Maiden Surname မှ Page 1 and 2 should be ment of Health and Me Informant's Name/Relationship (Type 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra iam] Baltimore, hod of Disposition 20b. Place of Disposition (Name of Date 27 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State ☐ Donation 5 ☐ Other (Specify) Funeral Service Li 10185 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death ^cnysician/ Di sseminate Intravascular Coas disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Physician/Medical Examiner Due to for the it any leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events or Attending Physician: The law requires that the death certificate be executed -ardiom 40b sate has been signed by the attending physician and page 2 should be detached for use as the burial-trar Due to (or as a consequence of): resulting in death) Last Division of Vital Records, (P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy Year Month Day Pregnant at time of death
Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 4 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? within 24 hours after death.

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 7, 2010 Physician 5:30 P^M Hilda <u>Briggeman</u> March /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Towson Year | If Under 24 Hrs. Edenwald Care Center Baltimore 5. Social Security Number If Under 8. Date of Birth (Month, Day, Year) Aug. 2,1913 Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 🖸 F 96 Director 214-01-3548 Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ral", or items 23a or 28a-f shov 1 ☐ Yes 2 📉 No Funeral Director Baltimore Maryland Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 2 any injury or other traumatic event, the Wedfoel Evan that the conce. 21286 U.S.A. 800 Southerly Road, Apt. 711 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Completed by 1 ☐ Yes 21 No Specify: Specify: 3 X Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 **Ethel** Hassell Stouter Mary Henry James 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21047 Fallston, Maryland <u>2120 Hampton Court</u> Linda A. Vanden Bosche 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3-11-2010 | Baltimore Moreland Mem. Park Maryland 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Towson, Maryland 21204 <u>1050 York Road</u> 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** lears congestive cardionisapathy /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if cry leading to infinite decause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). The law requires that the death certificate be executed signed by the attending physician and I be detached for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregrant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mod Month Dav Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, ð icate has been si page 2 should b 1 ☐ Yes 2 ☑ No 3 Probably 4 ☐ Unknown Completed Were autopsy findings vailable prior to completion of cause of death? 24a. Was an 1 □Yes 2 No 1 ☐ Yes 2 ☑ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to ca examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 🔁 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manne 28a. Date of Injury (Month, Day, Year) 28b. Time of Certification: 28d. Describe how injury occurred Injury at Work? Division 5 Pending investigation 1 atural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D24121

Registrar

State

31. Date filed (Month,

MAR 09

Type, Print)

21

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a)

ROSENBERGO

	_1	For State Registrar					Ce	ertifica	ate of	Death			Reg. No.	30	0	068
hysician	_	1. Decedent's Nam	ne (First, Mid	dle, Last)		20						2. Date of D Month	, Day	Σ	Year	3. Time of D
/Medical		OLLIE 4a. Facility Name (	If not inetitut	ion when other at	BROW			4h C#	TOWN O	r Location	of Doath	mari			of Death	
xaminer		OVERLEA		ING & R	ЕНАВ			В	ALTIM	ORE		0.00				
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=	- 1-	Usual Residence o 10a. State	f Decedent 10b. Count	ty N/A		10c. Cit	y, Town or I	Location								10d. Inside City
ctor cto	2	MD	BAT	TIMORE	-	-Di	INDALI	<b>⊢</b> Ва	altim	ore						1∏Yes
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Funeral	3	101 CEN	TER PI		Vas Decedei	nt Ever in U.	S 113	Z.	edent of H	lispanic ()	rigin? (Sne	ocify Vas or N	lo-		SA Sa Amer	ican Indian,
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Completed		Elementary/Seco		nest grade com	College (1-4a	or 5+)	life	DO NOT	use retired	d) _	St Of WORK	iy .	LAU	JNDR	Y	
Be		17. Father's Name								18. Moth	er's Name	(First, Middle Stewa	le, Maiden <b>T</b>	Surnam	ne)	
ုင	2  _	JOSEPH	BERI				T			LOUI		STEWA				
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ORIGINAL

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 23, 2010 **Physician** February 2:00 PM M Margaret B. Barker /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Gilchrist Hospice Towson 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug 7, 1924 Birthplace (State or Foreign Country) 6 Sex 7. Age (In vrs. last birthday **Funeral** Days Hours Maryland 1 □ M 2 🛱 F 220-20-2722 Aug Director 85 Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Health and Mental Hygiene. 10b. County 10c. City, Town or Location 10d. Inside City Limits event, the Medical Examiner must be notified at tv Yes 2 □ No Director MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 124 E. Melrose Avenue 21212 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ∐Yes 2 No If Yes, Give Year or Dates: 3altimore, Maryland 21215-0036 1 ∐Yes 21∑ No white ģ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) housewife own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked t any Injury or other traumatic everones. Conrad Geroge Buedel Margaret Pedrick ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William L. Barker/spouse 124 E. Melrose Avenue Baltimore, MD 21212 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ronald 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Licensee S. Wade Director 21201 Baltimore, MD 23a. art 1. Enter the disea e, or confplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, o heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cau (Final disease or condition resulting in death) Physician Dome /Medical Due to or as a lonsequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Little University Cause (Disease or injury Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Dav Year 5 ☐ Other (specify) □Yes 2 □No 9 Unknown 9 Unknown intributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ brilletion 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 🗆 No 1 Tes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 | ER/Outpatient 3 | DOA Other: 1 Yes 2 No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manper of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

Box 68760, P.0. Division of Vital Records, within 24 hours after deaun.

To the Funeral Director: Af

> State Registrar

29b. Signature and title of certifier

. Mame and adviss of person who completed cause of death (Item 23a) (Type, Print) Z. IIMO HU DOWNZING, M.D. 21

DHMH 17 Rev 1/2001

M.D

29c. License number

29d. Date signed (Month, Day, Year)

# Baltimore, Maryland 21215-0036

Division of Vital Records. P.O. Box 68760.

	Pleas	se Type or Print in I				-		gible.	
	1 For State	State of Marylar	•			/lental Hy	giene		
	Registrar  1. Decedent's Name (First, Middle,	/ act)	Cei	rtificate of	Death	2. Date of De	Reg. No. 2	010	06886
Physician	TO HW	Lasij		BAI	1.	Month 0,2	Dav	Year - 2010	3. Time of Death
/Medical	4a. Facility Name (If not institution,	give street and number)		4b. City. Town. o	or Location of Death	002		inty of Deatl	
Examiner		TRE IRVING	TON	0	IMORE		20	g	MORE CITY
Funeral		6. Sex 7. Age (In yrs.		If Under 1 Year Months Days		8. Date of Bir (Month, Da	th	9. Birtl	hplace (State or Foreign untry)
Director	223-28-4106	¹♥M 2□F 89	Yrs.	Monaro Bayo	110010	Nov 12	, 1920	Vir	ginia
land	Usual Residence of Decedent  10a. State 10b. County	10c. Ci	ty, Town or Lo	cation				1	10d. Inside City Limits
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or 28a-f sl or 28a-f sl benotified	10e. Street and Number	<u></u> _		10f. Zip Code			10g. Citizen	of What Co	untry?
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fer death v r items 23a	11. Marital Status	12. Was Decedent Ever in U Armed Forces? 1 □Yes 2 🛣 No	l.S. 13.	Was Decedent of h If Yes, specify Cub	Hispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No Rican, etc.)	)- 14. F	Race - Ame Black, White	
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ed within 72 hor ygiene.  Tr. fr. fr. m. diezil	(Specify only highest Elementary/Secondary (0-12)	grade completed)  College (1-4or 5+)	(Give	kind of work done DO NOT use retire	during most of work d)	ing	-		
Son Con	unk	unk		paint	ter		home :	improv	vements
tal H H doth even even even	17. Father's Name (First, Middle, L				18. Mother's Nam	e (First, Middle	, Maiden Suri	name)	unk
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d 2 sl th an thaur traur	19a. Informant's Name/Relationsh Thurman Robins		1	-	and Number or Rui 10u Stree		•	_	11216
f Hea f Hea frem 2	20a. Method of Disposition		Place of Dispo	sition (Name of		Date	20c. Location		
permitting 19, 19, 19, 19, 19, 19, 19, 19, 19, 19,	1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☑ Other (Sp	B LI Removal from State	сететегу, сгег	natory or other pla	ce)				
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	23a. Par 1. Enter the direase, or o show, or heart failure. List o	omplications that caused the deat nly one cause on each line.	th. Do not ent	er the mode of dyi	ng, such as cardiac	or respiratory a	ırrest,		Approximate Interval Between
Physician	Immediate use (Final disease or continuous in death)	_a_ Colu	inar	y A	tury	Dis	core		Onset and Death
/Medical Examiner	resulting in death)	Due to (or as a conseq	quence of):	1					
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w requires that the division of the should be detached letter by the should be detached letter by Physician of the physician	Part II. Other significant condition	s contributing to death but not res	sulting in the u	nderlying cause giv	ven in Part I.	23e. Did t	tobacco use c	ontribute to	the cause of death?
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ician: The certificate hector, page						perfo 1 □ Yes	2 Ne	death? 1 □ Yes	2 <b>X</b> No
siciar certif rector	25. Was case referred to medical examiner?	Hospital:		Oth	26. Place of Deat				
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oital o urs aff illed ir		la constitución de la constituci							
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, p	29a. Certifier 1 Certifying (Check only one) 2 Medical E	Physician: To the best of my kno xaminer: On the basis of examina and manner stated.	owledge, deat ation and/or in	h occurred at the ti vestigation, in my	ime, date and place opinion, death occur	and due to the red at the time,	cause(s) and date and pla	I manner as ce, and due	stated. to the cause(s)
To the within To the compl	29b. Signature and title of certifier	0.		29c. Licens	se number		29d. Date sig	gned (Monti	h, Day, Year)
	) B	PHYSI	CIAN	D 5	754.	3	3-	3-1	C
	30. Name and address of person w	ho completed cause of death (Iter	m 23a) (Type,	Print)	27 0	0 4		-	
State	31. Date filed (Month, Day, Year)	ho completed cause of death (liter 1940 10 A. Registrar's Sign	VV 13 A	+L/Imo	RO 17.	15/4 L	-11m01	Eb, A	121223
Registrar	MAR 09 20	110 Sensus A	gar	ACO.					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 010 06887 1- For State Certificate of Death Registrar 2. Date of Death 3. Time of Death Physician/ Decedent's Name (First, Middle, Last) 1348 hrs Medical Examiner March 6, 2010 <u>Murry Duncan</u> Byrd 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Baltimore** University Hospital 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs 8 Date of Birth (MM/DD/YYYY 6. Sex Funeral Country Maryland Months Davs Nov.13,1968 Director 218-72-6922 X_M 41 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Yes 2X No Monkton Baltimore 23a or 28a-f show MD Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21111 USA 3762 Houcks Road or items 23a Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, traumatic event, the Medical Examiner must be 1 Never Married 2 Married Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Yes 2x No white Pages I and 2 should be filled within 72 hours after inent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", o Specify: 4 Divorced If Yes, Give Year 1 Yes 2 No specify: 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Complet SelfEmployed Painter Baltimore, MD 21215-0036 12 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Laura M. Faulkner Be William E. Byrd III 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) 3762 Houcks Road-Monkton, Maryland 21111 William Byrd III-father 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) 1 Burial 2 Cremation 3 Removal from State Funeral Chapel and Forest Hill, Maryland Mar.8,2010 4 Donation 5 Other Specify. 22. Name and Address of Facility 21 Signature of Funeral Service Licensee Fineral Charel 16924 York Road Mo l and Cremetion Services Okton Maryland 2000 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Retween Onset and failure. List only one cause on each line Me dies Death a. Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed and g UNPENDED AMENDED ending physician use as the burial Physician/Medi Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Day 3 Ectopic pregnancy Month Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an page 2 should autopsy prior to completion of cause of certificate has performed? death? 1 🗸 Yes ✓ Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) the Hospital or Attending Physician: Division of Vital Be Hospital: 1 Inpatient 2 🗹 ER/Outpatient 3 🗌 DOA Other Nursing Home 5 Residence 6 Other After this 1 🗸 Yes ဥ 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Certification: Passenger auto fixed object collision Mar 6, 2010 1229 hrs 1 Natural 1 Yes 2 V No Pending the 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f, Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) Minor Road @ Jarrettsville Pike, Jarrettsville , Md. within 24 hours at (Specify) Major Road / Highway Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. **Medical** 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of ceftifie O.C.M.E. March 7, 2010 Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Laron Locke MD. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001 OCME 2006

OCME

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Q 0 I O 832 rene Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death niversity of Maryland altimere If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthdav 8. Date of Birth Birthplace (State or Foreign Country)
 T 7 **Funeral** 1 M 2 F Months Days Hours Min 4-1-1932 Director Yrs. VA 218-26-536 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director Yes 2 ☐ No MD Baltimore 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? ntal Hygiene. ed other than "natural", or items 23a or event, the Medical Examiner must be I Funeral 72 hours after death with 21201 833 W. Pratt Street Apt 217 S 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2X No Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Black Completed 3 Widowed 4 Divorced Specify: Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Unemployed unemployed na marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John Miller Thompson Annie Mae injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 1 and 2 s of Health item 27 Vanessa Ball-daughter 648 s. Paca Street Balto, MD 21230 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a Department of H Important: If ite any injury or ot 20c. Location - City or Town. State cemetery, crematory or other place, 1 XBurial 2 Cremation 4 Donation 5 Other (Specify) Zion Cemetery 3-8-2010 Lansdown, 22. Name and Address of Facility March East F/H 21. Signature of Funer * ervice 21202 1101 E. North Avenue Balto, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death ⊹ehysician/ disease or condition resulting in death) termina Danemetrz Medical Due to (or as a consequence of): Examiner respirator Sequentially list conditions. cause. Enter Underlying Due to (or as a consequence of, Exami law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Left fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year the 9 Unknown Unknown P.O. ed by tl signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an ate has bage 2 s autopsy Hospital or Attending Physician: The perform death? certificate 1 🗆 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medica director, Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: မ 1 Inpatient 2 PER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 Pending work within 24 hours after death.

To the Funeral Director: All completed filled in by the fu Accident 1 🗌 Yes 2 🗌 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) AU4176435D1826G 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) of Sheet Baltimore Day, State 09 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2:34 PM Day 2 Bell 2,2 Year Byron Jeffrey Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town or Location of Death **Examiner** 4c. County of Death albu ial Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Days **X**□ M 2 □ F Min. 18 Director 55 MD 217-64-7348 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD NA Baltimore 1X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2427 Shirley Ave 21215 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. 1 X Never Married 2 Married ģ Maryland 21215-0036 1 ☐ Yes 2X☐ No Specify. Completed 3 Widowed 4 Divorced Specify: Black Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Baltimore City (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Substitute Teacher 12th grade Public Schools 4vrs Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) <u>Benjamin E. Bell</u> Annie Elizabeth Byrd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Annie Bruce-Mother 2427 Shirley Ave, Baltimore, Md 21215 Baltimbre, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Most Holy Redeemer 3/6/10 Belair, Md 22. Name and Address of Facility
March F/H West 21. Skinal re of Funeral Service Licensee 300 Wabash Ave Baltimore, Md 21215 23a. Part 1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause ( Approximate Interval Between Onset and Death (CVA) with herejation Physician/ disease or condition resulting in death) C Medical days Due to (or as a consequence of): **Examiner** Gequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and dbe detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 Ho
9 Unknown Month Day Year Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Hoknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has be lirector, page 2 s autopsy performs Yes ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 🗌 Yes r this c ၉ Inpatient 2 ER/Outpatient 3 DOA Manner of Death

Natural

Accident Certificate: Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred After (Month, Day, Year) 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation within 24 hours after death To the Funeral Director, of completed filled in by the 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signeture and title of certifier 9117200 ornas 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

THOMAS GENUIT IS INAL HOSPITAL OF BALTIMOUSE

Registrar
DHMH 17 Rev 7/2009

State

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32 Registrar's Signatu

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Niloufar Behmanesh	1- For State	ate of Maryland	l / Departmer <i>Certificat</i>			Mental F			201	0 06891
*Physician/	Registrar  1. Decedent's Name (First, Midd	le,Last)	00/11/1041				2. Date of De		<u> </u>	3. Time of Death
Medical Examiner	Niloufar		В	ehm	anesh		Month March 3,	Day 2010	Year	1159 hrs
	4a. Facility Name (if not institution 2118 Charles Henry L	, 9	r)		City, Town, or Lo	ocation of Deat	th	- 1	ounty of Deat	
Funeral	5. Social Security Number		ge (In yrs. last birthd	ay)	If Under 1 Year	If Under 24Hr	rs. 8. Date of B	irth(MM/DD	/YYYY) 9. Bi	rthplace (State or
Director	212-33-2059	1 M 2 X F	<del>-46</del> 45	Yrs.	Months Days	Hours Mi	n. 04 2	1 6		_{puntry)} Iran
	Usual Residence of Decedent		45				P = 2	1 0.		11411
any	10a. State 10b. County		10c. City, Town or	Location	1					10d. Inside City Limits
and show	MD	NA	Bal	tim	ore					1 X Yes 2 No
Maryland 28a-f show any d at once. ector	10e. Street and Number		_		10f. Zip Code			10g. Citizen	of What Cou	intry?
ith the N 23a or notified al Dir	2118 Charles	Henry La	ne		212	209				
h with	11. Marital Status 1 X Never Married 2 M	12. Was Deceder			Decedent of Hispa , specify Cuban, I			0- 14.	. Race - Amer White, etc.	rican Indian, Black,
or items 23a or 28a-f sh must be notified at once Funeral Director		1 Yes	2 X No					5.0		rate data a
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5-0036 ed within 72 hour lygiene. other than "natu he Medical Exan Completed	12th grade	4yrs+		Un	employe	eđ		i	Unemp.	loyed
5-0( Figure 1999) Supplies the Market	17. Father's Name (First, Middle						ie (First, Middle,			
21215-0036 uld be filed within 7 Mental Hygiene. event, the Medical	Ataallah Beh 19a. Informant's Name/Relations	manesh				Soudab	eh Aze	emi		
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 37 is marked other than "matural", or items 33a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director					ddress (Street					21043
, MD and 2 sho ealth and em 27 is traumati	Yassaman Beh 20a. Method of Disposition	manesh-Si	ster 87	85 Disposition	Manahar on (Name of ceme	n Driv	e, Ell Date	i cot	t City of	Y Md r Town, State
Baltimore, permit Pages I ar Department of Hee Important: If ite	1 X Burial 2 Cremation	n 3 Removal from S	State crematory	or othe	place)		C /10			
ltim it. Pa rtmen ortant	4 Donation 5 Other S 21 Signature of Funeral Service				rial Pa		6/10	IMOO	dlawn	, Md
Ba perm Depa Imp	Man mon	Sithal	name)	Mar 430	ne and Address o Ch F/H O Wabas	West sh Ave	, Balt	imore	e, Md	21215
Physician	23a. Part I. Enter the disease, or failure. List only one cause	complications that cause								Approximate Interval Between Onset and
/Medical Examiner	Immediate Cause (Final disease	a Complica		inge	stion of	chemi	cal age	nt		Death
The second secon	or condition resulting in death)  Sequentially list conditions,	Due to (or as a con	sequence of):							
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nd nd ransit	events resulting in death) Last	Due to (or as a cond.	sequence of):							
ox 68760, suth certificate be executed attending physician and or use as the burial - transit sician/Medical Ex	UNPENDED	AMENDED#7,8	BperFH,G901,	3/9/2	010,WS/ 2	23a,27,	28a-f,p	erme (	3901 3	/18/10 TT
Box 6876/e e death certificate the attending phy ed for use as the hysician/M	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outc	ome of pregnancy	_	death 3	Ectopic pregr		23d. D	ate of deliver	y Day Year
Sox 6 leath cer e attendi for use	past 12 months?  1 Yes 2 No 9 ✓ Uni		at time of death 5	Othe	r (Specify)					
D. Box 6 to the death certain by the attend ached for use.  Physicia	Part II. Other significant condit	9 OHATOWIT	oth but not requiting in	a tha una	lockring course six	on in Bad I	23e Did	tobacco use	contribute to	the cause of death?
P.C	Fat II. Other significant condi-		ar but not resulting in	T (TIC GIT)	citying oddso giv	roman arci.				bably 4 🗸 Unknown
Vital Records, systian: The law requires his certificate has been significate, page 2 should be on the Completed on Be Completed							24a. Was			utopsy findings available completion of cause of
eco ne law te has ge 2 si		-			_		perf	ormed?	death?	
tal Rection: The certificate ector, page	25. Was case referred to medica	ıl			26.Place o	of Death (Check		2	· 💌 ·	
f Vital Physician: Trips certificated director To Be	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpat	ient 2 ER/Outp	atient	B DOA O	ther Nurs	ing Home 5	Residence	e 6 🗸 Othe	er: Scene
ing Ph After t Tuneral	27. Manner of Death	28a. Date of Ir (Month, Day	ijury 28b. Tin Year)	ne of Inju			28d. Describe	how injury	occurred	alagning
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Division constitution or Attending to ours after death.  Tilled in by the fant filled in by the fant Certification.	3 X Suicide 6 Cou	ld not be 28e. Place of	Injury - At home, farm		factory, office bui	ilding, etc.	28f. Location or Town,	(Street and State) 21	Number or Ri	ural Route Number, City rles Henry
Dospital hours hours y filled	4 Homicide		l: residen						11e, M	
Division of N Division of N To the Hospital or Attending Phy within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral edical Certification: T	(Check only	hysician: To the best of miner: On the basis of ex and manner stated	amination and/or inve							
Me	29b. Signature and title of certific	er			29c. License	number		29d. Dat	e signed (Mo	onth, Day, Year)
	hing h	, w=			O.C.M	I.E.		March	4, 2010	
$\phi$	30. Name and address of person Ling Li, MD Assista	who completed cause of ant Medical Examin		Street,	Baltimore, M	ID 21201		-		
State	31. DWAIR (0°9° 2010)		rar's Signature	,	·		<del>.</del>			
Registrar	MAIL 0 0 2010	penera p	7. parke							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 1 per doc 9901 3-16-10 vt. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Virginia Boice Bennett Day **Physician** Year GINIA 8:02AM /Medical 03 01 2010 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4001 Clarks Lane Apt 410 Baltimore 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2√ F Days Hours Months Min 11 Director 218-54-3207 60 18 49 MD Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show Lry or other traumatic event, I'm Medical Empirier in text be retified at 10b. County 10a. State 10c. City. Town or Location 10d. Inside City Limits Director MD 1 Yes 2 □ No NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4001 Clarks Lane Apt 410 21215 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married Married Baltimore, Maryland 21215-0036 2 If Yes, Give Year or Dates: 1 ☐Yes 2X No Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th grade na Disabled Disabled 17. Father's Name (First, Middle, Last) Be ( 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Mayfield Bennett Charlotte Skinner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21215 permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau Charlotte Bennett-Mother 4001 Clarks Lane Apt 410, Baltimore, Md 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cathedral 3/9/10 New Baltimore, Md 21. Signatur of Funeral Service Licensee March F H West 4300 Wabash Ave, Baltimore, Md 21215 23a. Partif. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart tailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Malignant disease or condition resulting in death) /Medical Due to (or as 1+ nsequence of): Examiner Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Directo (on as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Division of Vital Records. P.O. Box 68760. attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐Yes 2 💆 No Month Dav Year 5 ☐ Other (specify) detached 9 Unknown 9 Unknown 3 signed | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown certificate has been s rector, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □ No 24a. Was an autopsy performed? 1 ☐Yes 2 No this certific al director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 TResidence 6 Other (Specify) 1 Yes ≯ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DCA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Injury after death Director: / 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide e Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier To the Hosp within 24 ho To the Fund completely 1 one) TX CRNP 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) h, some 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

MAR 09

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2835

gus.

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 8 per inf g902 4-I-10 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death WILLIAM, MATHEW, BROWN Physician/ Mont 0.3 12:30P M 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE VA MEDICAL CONTER BALTIMORE 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country)
VA 8. Date of Birth (Month) Zay, **Funeral** Days Hours 1 □ M 2 □ F Director 226-18-9997 90 Jan. 6, items 23a or 28a-f show her must be notified at 10a, State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director n/a MD Baltimore Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2217 Henneman Ave. 21213 USA "natural", or item ledical Examiner n 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married ģ 1 Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Completed 3 Widowed 4 Divorced Specify: Black Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than Page 1 and 2 should be filed within ment of Health and Mental Hygiene. ant: If item 27 is marked other tha Elementary/Seconday (0-12) College (1-4 or 5+) long Shoreman Sparrows Point Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Brown, Sr. Beaulah Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2217 Henneman Ave. Balto, Md. 21213 Kim Fowlkes (daughter) item 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1
Department of I
Important: If it
any injury or o Mar.16,20 10 OwingsMills,MD Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) arrison Forest Vet: ature of Funeral Service Licensee 22. Name and Address of Facility
Calvin B. Scruggs Funeral Home Preston St. Balto, Md 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Respiratory Films Physician disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury the burial-tran that initiated events resulting in death) Last attending physician and Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 use as 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year sate has been signed by the spage 2 should be detached to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ESRD , Dementia, DM2, CVA, HTN 1 Yes 2 No 3 Probably 4 Conknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? certificate 2 No Yes 25. Was case referred to medical funeral director. æ 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred hours after death. uneral Director: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide the Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital within 24 hours To the Funeral Medical Fortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check 3 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1021 2010 M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE, MD 21201 HUANG II S. EUTAW ST. ANDREA 31. Date filed (Month, Day, Year) 32. Reistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			For State O' State Registrar	f Maryland / Depa <i>Cel</i>	artment of He <i>tificate of De</i>			iene _{eg. No.} 2010	06893		
	Physicia	n/	1. Decedent's Name (First, Middle, Last)  Mary Sue Bowman				Date of Death     3. Time of Death				
	Medic Examin	al	4a. Facility Name (if not institution, give street and number)  4b. City. Town, or Locati				March 5, 2010   2 A M				
			3328 Churchville Rd		Aberdeen			4c. County of Death Harford			
	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2 🗓 F	7. Age (In yrs. last birthday) 83 Yrs.		f Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 8/10/19	Year) 9. Bi Co NC	rthplace (State or Foreign ountry)		
	how at	'n	Usual Residence of Decedent  10a. State 10b. County	10c, City, Town or Lo	cation				10d. Inside City Limits		
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertall Hygiene. Department of Health and Mertall Hygiene. Inprostant: If item 27 is marked other than "natural", or items 23a or 28a-f show mary injury or other traumatic event, the Medical Examiner must be notified at once.	Director	Maryland Harford Aberdeen 1 - Yes 2 - Xwo								
		eral D	10e. Street and Number 3328 Churchville Rd.		10f. Zip Code 21001		Ü	0g. Citizen of What C JSA	ountry?		
9800		ted by Funeral	11. Marital Status  1 □ Never Married 2 ☒ Married  1 □ Nidowed 4 □ Divorced  12. Was Decernated For 1 □ Yes If Yes, Give Year or Data	ces? 2 🔼 No	Nas Decedent of Hisp f Yes, specify Cuban, I ☐ Yes 2 💆 No	Mexican, Puerto I	cify Yes or No- Rican, etc.)	14. Race - Ame Black, White White Specify:			
Baltimore, Maryland 21215-0036		Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Seconday (0-12)  College (1-	4 or 5+) (Give life. D	dent's Usual Occupation  kind of work done duric  NOT use retired)  maker	on ing most of workii	ng	16b. Kind of Business At home	Industry		
land	be filed ental Hy ked oth ic event	To Be	17. Father's Name (First, Middle, Last) Fletcher Spry	-		8. Mother's Name Gertrude					
, Mary	d 2 should alth and M 1 27 is mar er traumati		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Nur Lonnie F. Bowman / son  809 John Smith St. Havre de								
more	Page 1 an nent of He int; If iten iry or oth		20a, Method of Disposition  1   Burial 2 □ Cremation 3 □ Removal from 9  4 □ Donation 5 □ Other (Specify)	20b. Place of Dispo cemetery, cren Harford Me	sition (Name of natory or other place)	i		20c. Location - City of Aberdeen,			
Balti	permit. Departri Importa any inju		21. Signature of meral state of ee	22 Tr	Name and Address of	of Facility GO Funer	al Home	P.A.			
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as or shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition)								st,	Approximate Interval Between Onset and Death		
	Medical Examiner		resulting in death)  a. Due to (or as a consequence of):								
	uted nd ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events  C.								
00	le death certificate be executed the attending physician and shed for use as the burial-transit	edical E	resulting in death) Last  Due to (or as a consequence of):  d								
. Box 68760		Physician/Med	FFEMALE:   23b. Was decedent pregnant   23c. If yes, outcome of pregnancy   23d. Date of delivery						olivery Day Year		
ls, P.O.	uires that tl n signed by uld be deta	by	23e, Did tobacco use contributing to death but not resulting in the underlying cause given in Fart.								
Division of Vital Records,	The law req ate has bee page 2 sho	Completed	24a. Was auto period to the control of the control								
ita	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  Of the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Be	25. Was case referred to medical examiner?		Other	e of Death (Check	_		-		
of <		ite: To	27. Manner of Death 28a. Date of	npatient 2 ER/Outpatier f injury 28b. Time of n, Day, Year) injury	28c. Injury at work?		ne 5. Resider 8d. Describe hov		6 Other (Specify)		
vision		Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Honicide determined		M 1 ☐ Yes 2 ☐ No home, farm, street, factory, office			28f. Location (Street and Number or Rural Route Number, City or Town, State)			
Ö		Medical C	29a. Certifier (Check (Check 2   Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
	To the within 2 To the comple	M	only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)								
D				CIM		58475		mancet	5 2010		
			30. Name and address of person who completed cause PHTUTP NOWAT PURS NO 605			2 L ATLA	- mp o	1019			
ı	Stat Registra	e	31. Date filed (Month, Day Year)  AR 0 9 2010  32. Re	gistrar's Signature							

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

		1 _ State	of Maryland / Depa	artment of F rtificate of I						
		Registrar  1. Decedent's Name (First, Middle, Last)	Cer	lineale or i	Deain	2. Data of Dooth	6 Day 2010 ar	3 Time of Death		
	Physician   Carmen Doris Chiarelli				March			7:00 рм		
Examine	4a. Facility Name (If not institution, give street and number)  1 Smeton Place #501				4b. City, Town, or Location of Death			4c. County of Death Baltimore		
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	TOWSON If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Dec. 3,	Year) 9. Birthp	olace (State or Foreign		
Director	Director	118-26-9399 The Market Park Park Park Park Park Park Park Park	// Yrs.			Dec. 3,	1932 New	TOPK		
rryland show		10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limit								
ne Ma 18a-f s		Md. Baltimore Towson						1 ☐ Yes 2 🔀 No		
3a or 2		10e. Street and Number  1 Smeton Place #501		10f. Zip Code 2120	4	10	g. Citizen of What Cour			
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it. Medical Examinations to other traumatic event, it. Medical Examinations and its angles.	To Be Completed by Funeral	11. Marital Status 12. Was Dec	2 🕅 No ive	Was Decedent of H f Yes, specify Cuba I □Yes 2 🕅 No	lispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: Whi	etc.		
5-0		15. Decedent's Education (Specify only highest grade completed,	I (Give	dent's Usual Occup	durina most of worki	ng 1	6b. Kind of Business/Inc	dustry		
within iene.			1-4or 5+) Volunt	DO NOT use retired C <b>eer</b>	d)	Н	ospital Wor	<b>'</b> k		
Itimore, Maryland 21215-0036 it. Pages 1 and 2 should be filed within 72 hours aft riment of Health and Mental Hygiene. rtant: If Item 27 is marked other than "natural", or njury or other traumatic event, Its Modical Exerci-		17. Father's Name (First, Middle, Last) Hassie Howell		:	18. Mother's Name Rolendia					
, Mary and 2 shou salth and N 27 is mai		19a. Informant's Name/Relationship (Type. Print)  Yvonne Chiarelli/ Daughter  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  5376 Smooth Meadow Way #4 Columbia, Md. 21044								
imore Pages 1 ament of He ant: If Item ury or oth		20a. Method of Disposition  1 □ Burial 2 💆 Cremation 3 □ Removal from 4 □ Donation 5 □ Other (Specify)	State 20b. Place of Disponsion Commetery, crem				Towson, Md.			
Balt permit. Depart Import any inj once.		21. Signature of Euperal Service Licentee	Min 22	Name and Addre RUCK 1050	Towson Fu York Rd.	neral Ho Towson,	me, Inc. Md. 21204			
C8760, Children be executed / Medical Examiner   Examin	Completed by Physician/Medical Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, it also interests and cause or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):								
		in the past 12 months?	gnant at time of death 5	Ectopic pregnanc	cy		23d. Date of delive	ery Day Year		
cords, P. w requires that is been signed by should be deta								use contribute to the cause of death?		
		COMMUNIC ORSTME	eny Disc	MUNIMU MSE	4 DISCH	autopsy	prior to co led? death?	opsy findings available mpletion of cause of 2 \Bigsim No		
Vital F sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?		Oth	26. Place of Death	-	<u></u>			
Of B Phys er this eral dir	ا با ا	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred								
Division of Vita I or Attending Physician: after death. Director: After this certific d in by the funeral director,	Medical Certification: To	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Plac	e of Injury - At home, farm, strolling, etc. (Specify)	M 1 □	Yes 2□No	28f. Location (Str City or Town,	eet and Number or Rura , State)	al Route Number,		
ital ral		29a. Certifier  (Check only one)  (Check only on								
To the within To the comple		29b. Signature and title of certifier	$\cap$	29c. Licens	se number	29	d. Date signed (Month,	Day, Year)		
		1 Umut AJ	*how so	Do	0028817	2	3/8/10			
12		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7801 York Road Towson, Maryland 21204 Evangelos Lignos, MD								
Stat Registra		31. Date filed (Month, Day, Year) MAR 0 9 2010	Registrar's Signature	de						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 2010 Year March 5:50 P Jane Н. Casey Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Towson Gilchrist If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 🖎 F Hours Min. JWYV, Pro Year) 1954 Country) Maryland Director 215-48-4571 55 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Parkton 1 🗌 Yes 2 🙀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 1513 Mount Carmel 21120 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: White 3 Widowed 4XXDivorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Insurance Agent Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Howard Russell Hanna Jane Baker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Todd Casey / Son 1513 Mount Carmel Road Parkton, Maryland 21120 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Hillton Serv. Corp. 20c. Location - City or Town, State 1 Burial 2XXCremation 3 Removal from State 3/9/2010 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Towson, Maryland 21204 Signature of Funeral Service Licensee Ruck Towson Funeral Home, Inc. 1050 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate terval Betweer iset and Death Immediate Cause (Final -∤hysician/ 12515 disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate a consequence of) cause. Enter Underlying Cause (Disease or linjury that initiated events attending physician and I for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?

1 Yes 21 No 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Month Year been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 2 No 3 ☐ Probably 4 ☐ Unknown Completed 1 Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy performed? Yes 2 No death? 1 ☐ Yes 2 ☐ No funeral director, To Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director; After this 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 1 Tes 2 No filled in by the Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a, Certifier 1 Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated 3. only one) 29b. Signature and title of certifier License numbe 30. Name and address of person who completed cause of death (Item 23a), (Type, Print)

Registrar

State

AND N 31. Date filed (Month, Day,

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U | U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 03 - 77 - 201 0 0630P M Anna Caccamo Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Harford Bel Air 1119 Sunset Dr If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday 8. Date of Birth Birthplace (State or Foreign Country)
 D **Funeral** 1 □ M 2 😿 F Months Days 04-28-1919 Director 198-10-6757 90 PA Usual Residence of Decedent 28a-f shov 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Tant: If item 27 is marked other than "natural", or items 23a or 28a-f sho lury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 No MD Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21014 1119 Sunset Drive 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force þ 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 ₩ Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Housewife Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Savino Natale Guiseppina Rossi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 605 College Ave Lutherville, MD 21093 Theresa Bauernschub (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a Department of I Important: If ite any injury or ot Date 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 🗀 Donation 5 🗆 Other (Specify) Gardens of Faith D3-10-2010 Baltimore, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Schimunek Funeral Home of BelAir 610 W. MacPhail Rd Bel Air, MD 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Fitysician Due to as a consequence disease or condition Medical resulting in death) as a consequence of) Examiner oronar Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examin Cause (Disease or iinjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ▼ No
9 ☐ Unknown Day Year 5 Other (specify) n signed by the a g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has director, page 2 performed? Yes 2 No After this certificate function funeral director, page 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 KResidence 6 ☐ Other (Specify 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending injury М 1 Tes 2 No Investigation within 24 hours after death

To the Funeral Director:
completed filled in by the 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🛮 🗶 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b, Signature and titl 29d. Date signed (Month, Day, Year)

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State Registrar

DHMH 17 Rev 7/2009

2014 Tollgate

rson who completed cause of death (Item 23a) (Type, Print)

2010

## State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** UNICH KOWENA 'AUFA 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Reisterstown Future Care Cherrywood If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M **X**XF Months Days 93 April 8, 1916 W. Virginia 232-05-0760 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State show r 28a-f show notified at 1 Yes WNo Director Reisterstown MD Baltimore 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number "natural", or items 23a or dical Examiner must be U.S.A. 21136 343 Bryanstone Rd. ould be filed within 72 hours after death v Mental Hygiene. arked other than "natural", or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes **X** No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 Yes XXNo Specify: White ģ XX Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Own Home Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be if Health and Menta item 27 Is marked Ruth Snowden Russell Clayton ဥ Pages 1 and 2 should 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5533 Emory Rd. Upperco, Maryland 21155 Robert R. Martin / Nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Important: If it any Injury or o 1 ☐ Burial **XX** remation 3 ☐ Removal from State Metro Crematory Inc. 3/8/10 Baltimore, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Fine Servi Licensee 22. Name and Address of FacilitEckhardt Funeral Chapel F.A. 11605 Reisterstown Rd. Owings Mi**11**s, MD21117 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MEINELS SMSNITA 19ANS **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 physician Physician/Medical the attending ph for use as t IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 9□Unknown 9 Unknown signed k 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 Yes 2 No 3 Probably 4 Unknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2 No Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To 2 ER/Outpatient 3 DOA 1 Inpatient this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Watural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

To the Fune completely f

the

Medical

State Registrar

29a. Certifier

(Check only

31. Date filed (Month, Day, Year,

29h. Signature and title of certifie

KARUSIN C. SIAMING 2835 Smits DUE #203 BOLGIMON, MANY/AND 21209 32. Registrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

088852

Please Type or Pr State of M

rint in Black Indelible Ink. Ensure All Copies Are I Maryland / Department of Health and Mental Hygiene	Legible.	00000
laryland / Department of Health and Mental Hygiene	2010	10000
Certificate of Death		

		1- For State Registrar	Certific	cate of De	eath		Re	g. No.			
Physic	ian/	Decedent's Name (First, Middle,Last)					Date of Deatl     Month		Year	3. Time of Death	
ical Exam	iner	Vernon Tyrell Cooper		141.0	to Tour and a	antion of Dooth	Month February 2		atu of Dooth	1610 hrs	
		<ol> <li>Facility Name (if not institution, give street and num 8703 Hamlin Street</li> </ol>	ber)		ity, Town, or Lo enarden	Callott of Death	4c. County of Death Prince George's				
Funeral		5. Social Security Number 6. Sex 7	. 8. Date of Birt	n(MM/DD/Y	YYY) 9. Birtl	hplace (State or					
Director		579-90-9050 1 km 2 F	39	Yrs. M	onths Days	Hours Min.	03/25/	1070	Foreigi Cou	weshington	
	1	Usual Residence of Decedent					1 03/23/	1970		<del>- EC</del>	
any		10a. State 10b. County	10c. City, Town	n or Location						10d. Inside City Limits	
Maryland 28a-f show 1 at once.		MD PG	Cli	ntan						1 Yes 2 No	
Maryl 28a-1	Director	10e. Street and Number		10f	Zip Code		10	g. Citizen of	What Coun	try?	
215-0036 be filed within 72 hours after death with the Maryland mal Hyggiene. reted other than "natural", or items 23a or 28a-f sho ent, the Medical Examiner must be notified at once.	Ö	9405 Juliette Drive			20735			US			
th wit tems 2	Funeral	11. Marital Status 1 Never Married 2 Married Armed Ford			cedent of Hispa pecify Cuban, M		pecify Yes or No- Rican, etc.)		ace - Amerio Vhite, etc.	can Indian, Black,	
er dea	Fu	1 Yes 3 Widowed 4 Divorced If Yes, Give Year	2 X No	1 Ves	2 X No s	necify:		Spec	itv: Bla	ack	
ars aft tural"	ğ	or Dates:  15. Decedent's Education (Specify only highest grade	completed) 16a.		sual Occupation		vork done		f Business/Ir	25	
5-0036 led within 72 hours tygiene. other than "natur the Medical Exami	Completed	Elementary/Secondary (0-12) College (1-4		during most of	working life. Do	O NOT use reti	red)				
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5-0 lled w Hygic I othe	ပိ	17. Father's Name (First, Middle, Last)			18.		(First, Middle, M	aiden Surna	ame)		
21215-003 uld be filed with Mental Hygiene marked other tl	å	Wonzell Cooper  19a. Informant's Name/Relationship (Type, Print )	170	Ob. Marilia a Ada			Chinson Rural Route Num	0.1	Taura Chata	Zin Code\	
MD 21215-0036 12 should be filed within 7 th and Mental Hygiene. 12 is marked other than umatic event, the Medica	1	Tonya M. Cooper - Sister		•	,		on, Maryl			Zip Code)	
2 7 7 7		20a. Method of Disposition	20b. Place	of Disposition	(Name of cemet		Date	20c. Locati	on - City or	Town, State	
DOFE 1 of H 11 of H 11 If i	Ш	1 Burial 2 Cremation 3 Removal from	ii State	atory or other pl		03/	/ng/2010	Polto	- <del> </del>	MO	
Baltimore, permit. Pages I a Department of He Important: If ite injury or other to	4 ponation 5 Other Specify: Chesapeake Crematory 03/09/2010 21. Signature o Funeral Service Licensee 22. Name and Address of Facility December 1								Deltsville, MD		
Ba Perm Depi Imp		21. Signature o Funeral Service Licensee  22. Name and Address of Facility Freeman Funeral Services  4594 Beach Road: Temple Hills, MD 20748  23a. Part I. Enter the discass, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory great, shock, or heart Approximate Interva									
Physician		23a. Part I. Enter the discusse, or complications that cau- hait re. List only one cause on each line.	ised the death. Do n	not enter the me	ode of dying, su	ch as cardiac o	r respiratory *rre	st, shock, or	heart	Approximate Interval Between Onset and	
/Medical			unds of Head a	and Abdom	en					Death	
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	<u>,</u>	Sequentially list conditions, if any, leading to immediate b. Due to (or as a c	onsequence of):							-	
	<u>ĕ</u>	cause. Enter Underlying Cause									
ed ssit	Examiner	events resulting in death) Last  Due to (or as a continuous)	onsequence of):								
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760, icate be e physicia	Medical		itcome of pregnancy					23d Dat	e of delivery		
6876 certifical ading ph	ng/k	23b. Was decedent pregnant in the past 12 months?		7 2  Fetal de	eath 3	Ectopic pregna	incy	Mont		ay Year	
Box 687 e death certifu the attending ed for use as t	sici	4 Pregnar		5 Other (	Specify)						
. Be de y the de fe	Physician	Part II. Other significant conditions contributing to c	CONTRACTOR OF THE	ng in the under	lving cause give	en in Part I	23e Did to	pacco use c	ontribute to t	he cause of death?	
P.O. B es that the d igned by the	δ	Fatti. Other significant conditions congressing to	Jean Dat Hot resulti	rig in the diluci	lyllig cadse give	armir carri.				ably 4 Unknown	
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ital ician s certi	B B	25. Was case referred to medical examiner?  Hospital: 1 Int	patient 2 ER/C	Outpatient 3		Death (Check	g Home 5 1	Residence	6 Other	Scene	
of V ing Phys After thi uncral di	임	27. Manner of Death 28a. Date of	Injury 28b.	. Time of Injury	28c. Injury a		28d Describe h			-	
Division of Vital Records, tal or Attending Physician: The law requiring and or Attending Physician: The law requiring a flowed or After this certificate has been seen in by the funeral director, page 2 should it	텒	1 Natural 5 Pending FOUND:		UND: 57 hrs	1 Yes	2 🗸 No	Subject shot				
ivision or Atten after death Director:	fical	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place	of Injury - At home,		tory, office build	ding, etc.			ımber or Rur	al Route Number, City	
Division of Vital I pptal or Attending Physician: ours after death. filled in by the funeral director,	Certification:	4 Homicide determined (Specify)	Found in auto				or Town, St Found 8703 H	ate) amlin St., (	Glenarden,	MD	
Hos 74 h Fur		29a. Certifier 1 Certifying Physician: To the best	of my knowledge, de	eath occurred a	it the time, date	and place, and	due to the cause	e(s) and mar	ner as state	d	
To the Hos within 24 h To the Fur completely	Medical	one) 2 Medical Examiner: On the basis of and manner sta	examination and/or ted	investigation, i			it the time, date a				
. , , ,	Σ	29b Signature and title of certifier			29c. License n				-	th, Day, Year)	
_		( tatohum)		0.7	O.C.M.	<u> </u>		repluar	y 26, 201 	0	
	П	30. Name and address of person who completed cause			ant Daltina	re, MD 212	01				
	9 44	I STON LOCKS MILL Accietant Madeical		I Pann S	ppi Rammo						
	tate	Laron Locke MD. Assistant Medical  31. Date filed (Month, Day, Year)  MAR 0 9 2010  32. Fig	istrar's Signature	bark		, WID 212					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month March Physician/  $20\overset{\text{Year}}{10}$ Jerome Anthony Casciero Jr. 5 3:07 A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Harford Upper Chesapeake Medical Center Bel Air 8. Date of Birth
(Month, Day, Year)
Dec. 6, 1955 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
Maryland Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 🛛 M 2 🗆 F Months Days Min. Hours 54 **Director** 218-68-1471 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director er than "natural", or items 23a or 28a-f s the Medical Examiner must be notified 1 Yes 2 No Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2514 Deer Valley Way 21015 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Completed 3 Divorced 4 Divorced White Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Owner Operator Auto Body 27 is marked other traumatic event, t Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H ၉ t. Page 1 and 2 should be rtment of Health and Men rtant: If item 27 is mark Jerome Anthony Casciero Sr Ursula Catherine Dohler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 any injury or other tr Nancy Spence-Casciero / Wife 2514 Deer Valley Way, Bel Air, MD 21015 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) lltop Service Corp. 3-8-10 Towson, Maryland ²² Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, 23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Metastanc Testicular Cancer nknmn disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Alveolar Hemorrhage unknown Sequentiany list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that intitated see or the conditions of the cond Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Accident Cembrovascular nknay that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Renal nknon ecords, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
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Christa Fyllen MD 500 Upper Chusa peake Drive, Bell Air, MD 21014

State Registrar

Jerome Anthony

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year mores 12:30 PM Leonard Medical OIC 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimor If Under 24 Hrs If Under 1 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 10 M 2 □ F Months Hours Min. (Month, Day, Director Usual Residence of Decedent ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Funeral Director 10d. Inside City Limits 1 ☐ Yes 2 No ETHORPE timore AL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2122 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? , or Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced Year or Dates Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical 15, Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) raramodic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Koad 20a. Method of Disposition
1 □ Burial 2 ☑ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery crematory of other plants of the pl 4 ☐ Donation 5 ☐ Other (Specify) 2010 22. Name and Address of Facility 6934 Signature of Funeral Service Licenses YORKROAD, MONKTON MD 21111 Evans 23a. Part 1. Enter the dispase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List doly one cause on each line. Approximate Interval Between Onset and Death Physician/ disease or condition resulting in death) north Medical Due to (o() s a conse of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of) been signed by the attending physician and should be detached for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IE EEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 5 Other (specify) Day Year 1 Yes 2 9 Unknown 4 ☐ Pregnam : 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an DV hasl autopsy performed? Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate 1 ☐ Yes 2 ☐ No completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 3 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) 000 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Belline SINAI MAINISM TALW MBBS MOSPITAL OF Baltimore 2401 31. Date filed (Month, Day, Year) 32. Registrar's Signature

Registrar DHMH 17 Rev 7/2009

State

MAR 09 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month. 725 AM COHEN 0/05 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** NORTH OAKS HEALTH CENTER PIKESVILLE BALTIMORE 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 12/03/1919 Days Hours Min. Country) MD 90 Yrs Director 219-05-5088 Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 💢 No MD BALTIMORE PIKESVILLE 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 725 MT WILSON LANE 21208 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes : Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No 3 Nidowed 4 □ Divorced WHITE Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done life. DO NOT use retired) (Specify only highest grade completed, during most of working Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ NATHAN BORENSTEIN DORA ATKIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JANET SALKIN / DAUGHTER 100 HARBORVIEW DRIVE, #2202, BALTIMORE, MD 21230 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BETH TFILOH CONG. 03/07/2010 WOODLAWN, MD 22. Name and Address of Facility SOL LEVINSON & BROS., 21. Signature of Funeral Service License 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ SCHIAI disease or condition resulting in death) Medical **Examiner** Secretally list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury the Hospital or Attending Physician: The law requires that the death certificate be executed tensio that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year Yes 2 No 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Tes 25. Was case referred to medical 26. Place of Death (Check only one) 2 No Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28d. Describe how injury occurred Natural injury 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation within 24 hours after deat To the Funeral Director: 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Murse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of 29c. License number 0068252 Stephen 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Greenspan

DHMH 17 Rev 7/2009

State Registrar 4000

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Baltimore, Maryland 21275-0036

Division of Vital Records, P.O. Box 68760,

1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** Maria Ester Sjoberg Ferreira de Carvalho 2010 /Medical 4a. Facilify Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner sedale ar If Under 24 Hrs. ITal Birthplace (State or Foreign Country) 5. Social Security Number Y. Age (In yrs. last birthday) 8. Date of Birth Funeral Year) Days Hours Min. 1 □ M 2 X F Months 213-87-0926 Yrs. 47 Director 1962 Sao Paulo, Brazil 20, Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Even inscribed by actified at 1 ☐ Yes Ž No Director Maryland Baltimore County Cockeysville 10e, Street and Number 10g. Citizen of What Country? ō 10002 Hillgreen Circle items 23a Apt.H. 21030-3788 Brazil Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married n and Mental Hygiene. Specify: Brazilian 1 ☐ Yes 2 🗙 No Specify: \$ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 04 Home Maker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Sylas Sjoberg Ferreira Maria Aparecida de Oliveira Sidoero Ferreira Pages 1 and 2 should 19a. Informant's Name/Relationship (Type. Print) (Husband) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important; If Item 27 is any injury or other trau Paulo Batista de Carvalho, Ph.D. 10002 Hillgreen Circle Apt.H. Cockeysville, Maryland 21030-3788 20b. Place of Disposition (Name of cemetery, crematory or other place)

Evans Funeral Chapel March 10,2010 Forest Hill, Maryland 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Specify) permit. 22. Name and Address of Facility
Peaceful Alternatives Funeral & Cremation Center, P.A. Jeffrey L. Gair, Sr. 2325 York Road Timonium, Maryland 21093, U.S.A. 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Sho disease or condition resulting in death) /Medical Due of (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mm 1 ☐ Yes 2 ☑ No Year Day 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 1 ☐ Yes 1 ☐Yes 2 ☐ No 2 1 No funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manuer of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? (Month, Day, Year) 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 24 hours after death Funeral Director: filled in by the Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day. Year) 2 3.5.2010 X6300000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000, FRANKLIN SQUARE DRIVE, DEPTOFINTERNAL MEDICINE. MD. 21237. S. NADIGER 31. Date filed (Month, Day, Year) Registrar's Signature State backe Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Vear Month Day Marc 10:30 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner andallstown Raltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral Year) 924 Months Days Hours 1 □ M 2 🕟 Mary lane 216-20-636 March Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 Nes 2 No STOWN Director to more 10f. Zip Code 10g, Citizen of What Country? 10e Street and Number Completed by Funeral al 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. filed within 72 hours after 1 ∐Yes 2 【 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 NO 1 ☐ Yes 2 TUNO Specify. Specify: 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygis Important: If item 27 is marked other any injury or other traumatic event, II Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ima.r 0 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baitimou lilahman Drother Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition 20c. Location - City or Town, State 1 □ Burial 2 □ Cremation 3 □ Removal from State 10/2010 4 □ Donation 5 □ Other (Specify) 21. Signature of Feral Service Lansee 22. Name and Address of Facility ttome MD 2120 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Obstructive h-onic Winons /Medical Due to (or as a consequence of): Examiner dines 生しられ たる 1400 Ocquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Compliani with and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical ase If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy fort in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 🗷 No 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1al 2 🗌 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☒ No 24a Was an has autopsy performed? certificate 2 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📆 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 24 hours after death. • Funeral Director: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 29a. Certifier cal Two Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

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LIBERTY HEIGHTS AVE, BALTIMORE, MD 21215

State Registrar MOCTEMISI

32. Registrar's Signature 31. Date filed (Month, Day, Year) Lenon ORIGINAL

M.O

2600

>0 00 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SUSANYA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 10:00 PM Jane Ε. Chiveral March 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Regional Hospita Prince Laurel George's If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🔀 F Months Hours Min Days Yrs. 28, 219-32-0924 Feb. Maryland Director 1936 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 27 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be recified at 1 ☐ Yes 2X No Director MD Burtonsville Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3900 Blackburn Lane, Apt. 11 20866 Funeral death v 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or iter 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2\(\text{X}\)No Specify. <u>ک</u> Specify: White 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeper Accounting 12th Ø 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clifford Browne Lillie ပ Μ. German 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If Item 27 Is any Injury or other trains once. Carl E. Chiveral/Son 1265 Vogt Avenue, Apt. A, Arbutus, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2XXCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) West Arundel Crem. 3/9/2010 Odenton, MD 21 Signature of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral Home, P.A. M01103 313 Talbott Avenue, Laurel, MD 23a. Part 1 ther the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, it heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediat - ause (Final Physician Disease Exacerbation rulmonary Days disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the attending physician and ned for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant In the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) signed by the a d be detached for ☐Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 1 X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No cate has b page 2 sl 24a. Was an certificate 1 Yes 2 No the Hospital or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check onl one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral dir Certification: To 27. Manner of Death
Natural
Decident 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation ieral Director: A 1 ☐ Yes 2 ☐ No death. 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide within 24 hours a Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number D64818 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Laurel, MD 7300 Van Dusen Rd Regional .lacer Hospital Jason Lee-L aurel 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** HEROD /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner The Johns Hopkins Hospital **Baltimore City** 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 6. Sex 1 X M 2 □ F . Age (In yrs. last birthday) **Funeral** Director 54 07-05-1955 Pennsylvania 212-64-8514 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene.

ant If Item 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director 1 Yes 2 No Anne Arundel Crownsville 10e. Street and Number 10q. Citizen of What Country? 10f. Zip-Code 1046 Tudor Drive 21032 United States 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 🏋 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Specify þ Specify 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Project Manager Verizon 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Sherod Monroe Cooper, Jr. မ Janet Williams 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 is
any injury or other trau Debra H. Cooper / Wife 1046 Tudor Drive Crownsville, Maryland 21113 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Arundel Crematory 03-08-2010 21. Signature of Funeral Service Ligenses 22. Name and Address of Facility Donaldson Funeral Home & Crematory, P.A. 1411 Annapolis Road Odenton, Maryland 21113 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Part 1 Approximate Interval Between Onset and Death Immediate Cause (Final Failure **Physician** Heart disease or condition resulting in death) /Medical Due to (or as a consequence of) Cardiomyoputh **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a for seque ce of) The law requires that the death certificate be executed physician and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical as attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 2 🗌 No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Completed 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe 1 ☐ Yes 2 ☐ No certificate 25. Was case referred to medical completely filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 \(\sum \) Nursing Home 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA မ 5 Residence 6 Other (Specify) 27. Manner of Death 1 X Natural 2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred I or Attending P after death. Director: After tl 5 Pending investigation Injury 1 Yes 2 No 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 24 hours a Funeral C CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifiei Medical (check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. 29c. License number 29b. Signature and itle of certifier 29d. Date signed (Month, Day, Year) RES-OOC 7010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Brian 600 North Wolfe St, Baltimore, MD, 21287 Houston 31. Date filed (Month, Day, Year)-State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

10-01816

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Suzanne Curry		For State	St	ate c	of Marylar	nd / E	Departm Certific			d Men	ıtal Hygi		eg. No.	201	0	06906
Physician/ Medical Examiner		Decedent's Name Suzanne	,		Beth	(	Curry				1	Date of Deat Month Narch 3, 2	Day	Year		3. Time of Death 1022 hrs
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Funeral Director	2	Social Security No. 216-92-52	umber	6. Sex	м 2XF		n yrs. last bir 48	thday) Yrs.	If Under 1 Year Months Day	_	Min	Date of Bird				nplace (State or Nashington DC
nnd show any nce.	10	Usual Residence of Decedent  10a. State  10b. County  MD  Prince George's  10c. City, Town or Location  Greenbelt								- 1	10d. Inside City Limits  1 Yes 2 No					
h the Maryland 3a or 28a-f sh lotified at onco	10	e. Street and Num		t Ro						0790			Ur	izen of Wha nited	Sta	tes
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatite event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	11 3	, Marital Status  Never Marrie  Widowed		arried orced	12. Was Decedor Armed Ford 1 Yes If Yes, Give Year or Dates:		No	If Yes	Decedent of His, specify Cubar es 2 X No	n, Mexican specify:	n, Puerto Rica	an, etc.)		White,	etc. Wh	an Indian, Black,
5-0036 ed within 72 hours tygiene. other than "natur he Medical Exam Completed It		5. Decedent's Ed Elementary/Secon	ndary (0-12)	T	y highest grade College (1-4 5+			during mos	Usual Occupa t of working life L Worke	DO NOT				Kind of Busin		rvices
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Baltimore, permit. Pages I an Department of Hea Important: If iten injury or other tra	20a. Method of Disposition  1 Burial 2 X Cremation 3 Removal from State  4 Donation 5 Other Specify.  20b. Place of Disposition (Name of cemetery, crematory or other place)  Chesapeake Crematory  3/8/2010  Beltsvi									i11						
Ball permit Depart Impor injury		Signature of Fur	SA) XX	Ris	11,111		e382	1933	me and Addres Tuner Gist A	ve.,	Silve	r Spri	ing.	, MD	209	10
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cords, P.O. Box 6876i law requires that the death certificate has been signed by the artending phy 2 should be detached for use as the t repleted by Physician/IM.	23k	past 12 months	?		1 Live bird	th ntattim		2 Feta	death 3 r (Specify)	Ectopio	c pregnancy			Month	Da	ay Year
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N I S	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cand manner stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month)  March 4, 2010															
1 Server	30	Name and addre			ompleted cause edical Exam			n Street,	Baltimore,	MD 212	201		l			
State Registrar	4	. Date filed (Monti					Signature	2000								
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Date of Death
 Month Physician Day Year Chrest 1015 AM trunk March 2010 /Medical 4a. Facility Name (If not institution, give street and pumber) 4c_County of Death
Baltmore Examiner 4b City, Town, or Location of Death 21224 Johnstopkins Bayview Care Center Baltimone MD If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. JULY 6, 1912 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ★ M 2 □ F 219-18-7390 MD Director Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 28a-f show 10d. Inside City Limits 늄 Pages 1 and 2 should be filed within 72 hours after death with the Marment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f slury or other traumatic event, Ite Medical Examinat must be nother. Director MD N/A 1 X Yes 2 □ No BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4422 FOREST VIEW AVE 21206 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11. Marital Status 1 | Yes 2 | If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐Yes 2 No Specify. Specify: WHITE 3 XWidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 4+ College (1-4or 5+) Elementary/Secondary (0-12) SCHOOL TEACHER BALTIMORE CITY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be CHARLES T. CHREST LILLIAN I. AMOSS ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BOB CHREST-SON 1511 AVIEMORE PLACE BEL AIR, MD 21015 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1
Department of IImportant: If ite
any Injury or ot 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) PARKWOOD CEMETERY 3/8/10 BALTIMORE, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility MILLER-DIPPEL FUNERAL HOME, INC 6415 BELAIR RD BALTIMORE, MD 21206 23a. Rart 1. Enter the disease, or cl shock of heart failure. List or ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest e cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** spiration frommonio Wours /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Clisease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) physician and the burial-trans Due to (or as a consequence of): Physician/Medical attending p for use as 1 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year 5 Other (specify) ed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 ☐ Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 27 No should ! 1 🗌 Yes 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2/**D**/No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ funeral 27. Manger of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

The law requires that Division of Vital Records, or Attending Physician:

Baltimore, Maryland 21215-0036

the death certificate be executed P.O. Box 68760, To the Hospital or Attendin within 24 hours after death.
To the Funeral Director: Af completely filled in by the fur

State

Registrar

31. Date filed (Month, Day, Year) MAR 09

29b. Signature and title of certifier

29a, Certifier

Medical

completed cause of death (Hem 23a) (Type, Print)

and manner stated

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year) March 4, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March 1,2010 Geraldine S. Dize 7:45P Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death 4b. City, Town, or Location of Death 160 Drexel Drive Bel Air Harford 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 🗆 M 2 🛂 F Months Days Hours December 22,1923 West Virginia 235-30-3554 86 Director Yrs. Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 10c. City, Town or Location 10d. Inside City Limits Md. Harford BelAir 1 Yes 2 X No 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be Completed by Funeral 160 Drexel Drive 21014 USA items 12. Was Decedent Ever in U.S. 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Examiner Black, White, etc. 1 Never Married 2 Married ò Yes 2 No Baltimore, Maryland 21215-0036 3 Widowed 4 Divorced If Yes, Give Year or Dates 1 ☐ Yes 2 🛣 No Specify "natural", Specify White the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene Home marked other t Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ို့ဝ Ira F. Shaffer Mona Cross 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Department of Health Important: If item 27 any injury or other to Brian Dize (Son) 160 Drexel Drive Bel Air, MD 21014 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest VA Cem 03-15-2010 Owings Mills, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home of Bel Air Bu Md Inc 610 W. MacPhail Rd Bel Air, MD 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician, ementla disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or in jury that initiated events resulting in death) Last Examine Due to (or as a consequence of): attending physician and for use as the burial-transit death certificate be executed Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Year Pregnant at time of death Dav signed by the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, ETTENSION 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed peen insons 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has autopsy performed page certificate 1 Yes 2 No Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical æ 26. Place of Death (Check only one) Hospita 1 Tes 2 19 No ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at within 24 hours after death.

To the Funeral Director: After t
completed filled in by the funera 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined

State

Medical

29a. Certifier

only one) 29b. Signature and title of certified

Mally

DON

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

. D

32. Registrar

5901

1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

10

MAY (AND)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

North CHarles

as Baltimore, Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Yea 3 moren Willie Dillard Sr. 010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death ltimore Hospital Baltimore er 1 Year If Under 24 Hrs.
Davs Hours Min. 8. Date of Birth
(Month, Day, Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Country) Director 231-40-1992 Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 No Randallstown Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Completed by Funeral 5 Sulky Court, Apt. 202 21133 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🏹 No If Yes, Give Specify. African-American 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Cab Driver Transporation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဥ Edward Dillard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Emma Dillard/Wife 5 sulky Court, Randallstown, MD 21133 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 8-2010 Glen Bronie, M Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home P.A. of Balto. Co. 9200 Liberty Road. Randailstown, MD 21133 3a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Angurusm Physician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner hemo thorax Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): been signed by the attending physician and should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury neumonia that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Hypertension, Coronary artery 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ieral Director: After this certificate has filled in by the funeral director, page 2.3 autonsv performed? 1 ☐ Yes 2 ☑ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 옏 1. Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 24 hours after deat Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completed (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one 29b. Signature and title of certifier

State Registrar dress of person

MAR 09

Date filed (Month, Day,

DHMH 17 Rev 7/2009

Hospital

who completed cause of death (Item 23a) (Type, Print)

32. Redistrar's Signature

March

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year ANT HON' 1 M 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death och Raver Commundy Levin 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Funeral Months Days Hours Min (Month, Day, Yea 1 ★ M 2 □ F **Director** 216-20-1492 86 18, January Pennsylvania Usual Residence of Decedent or 28a-f show 10a. State 10b. County "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Md. Baltimore Sparrows Point 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2805 Ritchie Ave. 21219 USA death v 12. Was Decedent Ever in U.S. Armed Forces?

1 Y Yes 2 No
If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 hours after 1 ☐ Yes 2 No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 nent of Health and Mental Hygiene. ant: If item 27 is marked other than " Elementary/Seconday (0-12) College (1-4 or 5+) 12 Years Civil Engineer Steel Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Anthony Doyle Dorothy King 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mildred Doyle Wife 2805 Ritchie Ave. Sparrows Point, Md. 21219 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) March 9, 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important; If ite
any injury or ot 1 Burial 2X Cremation 3 Removal from State Bayview Crematory 4 Donation 5 Other (Specify) Baltimore, Maryland 2010 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Prysician Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine Due to for as a consequence on the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last and the burial-trar Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as 1 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ be detached for in the past 12 months? Pregnant at time of death Yes 2 No 9 Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has autopsy 1 Yes 2 No certificate 1 Yes 2 No completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 No. မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DCA 4 Nursing Home 5 Residence 6 Other (Specify, After this 27. Mann of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 Natural 5 Pending injury Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 24 hours Medical 29a. Certifier 🖳 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltemen Living lenky Kaurn mmur. 4 3900 32. Registrar's Signatur State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month ZEBBIE EBRU 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BAITI MORE SECOURS 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth

June 7, 1934 9. Birthplace (State or Foreign Funeral 1 🕅 M 2 🗆 F Months Days Hours Maryland **Director** 214-32-0679 75 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD 1 Yes 2 ☐ No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 501 W. Franklin Street 21201 USA permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married þ ☐ Yes 2 🗓 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify. 3 Widowed 4 Divorced Specify: black Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry unk (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) factory worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Wesley Dawson Sally Mae Gibson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jenna Banks/niece 6245 Elizabeth Street Hurlock, MD 21643 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☑ Other (Specify) in state 21. Signature of Euneral Sorvice Licensee ROHALD S Wadd State Anatomy Board 655 W. Baltimore Street Wirector Raltimore MD 20a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shoot or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Due to (or as a Onset and Death Physician/ PNEUMONIA Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Physician/Medical yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death
☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year g Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ DEMENTIA Records, Completed 1 Yes 2 No 3 Probably 4 Unknown PULMONARY Were autopsy findings available prior to completion of cause of 24a. Was an OBSTRUCTIVE page 2 s autopsy performed 1 Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 24 hours after death. Funeral Director: A 1 Yes 2 No Accident Investigation 6 Could not be the 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the within 2 29b. Signature and title of certifier

State Registrar omen

31. Date filed (Month, Day, Year)

no

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Box 68760

P.0.

of Vital

Division

SECOUPS

29c. License number

HUSPITAL

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2010 March 2, Physician/ 9:12 AMM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany Allegany Health Nursing & Rehab Cumberland 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 6. Sex **Funeral** Months (Month, Day, Yes West Virginia 1 □ M 2 🔯 1924 212-54-8342 Director 85 Usual Residence of Decedent 28a-f show 10a, State 10c. City. Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland the Medical Examiner must be notified at Director 1 Yes 2 No MD **Allegany** Cumber land 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 730 Furnance Street 21502 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces? Black, White, etc. "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: Ves Give white 3 X Widowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) housewife own home other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental F ၉ Hendrick Lantz Flossie Marie Wilson 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any Injury or other trau Box 806 Bryanstown, MD George Davis/son 20617 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation & Other (Specify) Signati its of Funeral Social State MAddesoff Board 655 W. Baltimore Street irector Baltimore. MD Part V. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pitysician disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of, Exami burial-transit and Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 1 Yes 2 L 9 Unknown ate has been signed by the page 2 should be detached Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28h Time of 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1-Natural 5 Pending Investigation
6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title 29d. Date signed (Month, Day, Year)

Registrar

State

30. Name and addr

NAR 09 2010

pleted cause of death (Item 23a) (Type, Print)

32. Registrar's S

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Physician/ Downie line Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Bultimore Washington top 8. Date of Birth (Month, Day, Year) May 4,1959 Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Funeral 1**X** M 2 □ F Months Davs Hours 212-78-9868 Ireland 50 Director Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.

The strip and Mental Hygiene.

The strip and the strip "Instruct", or items 23a or 28a-f show often transitic event, the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County Director 1 ☐ Yes 2X No MD Anne Arundel Severn 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 8136 Silo Court U.S.A. 21144 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Tech Representative Northrop Grumman Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) James William Anderson Downie Bridget Mary Irene Feehan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Mrs Ann Downie/Wife 8136 Silo Court Severn, MD 21144 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State March 10, 1 Durial 2 X Cremation 3 DRemoval from State 2010 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 22. Name and Address of Facility Singleton Funeral & Cremation 21. Signature of up at Service Licensee Services PA 1 2nd Ave. SW Glen Burnie, MD 21061 234. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Non Small Cell Pnysician/ Councer SOM Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Due to (or as a consequence of): rate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Cause (Disease or liniury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical the Hospital or Attending Physician. The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Month Vear 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy this certificate within 24 hours after death.

To the Funeral Director, After this certifica completed filled in by the funeral director, to 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 1 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work?
1 Yes 2 No 27. Manner of Death 28a. Date of injury 28b. Time of 28d. Describe how injury occurred (Month, Day, Year) Natural Accident 5 Pending Investigation 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Could not be 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

State 31. Date filed (Month, Day, Year) Registrar AAR 0 9

32. Registrar's Signature

A. Sale

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month Dav Physician/ PM 200 Morc 13:10 Serguei Evt toukhov (n) Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** N/A Ballimore Baltimore Sinai Hospital of City If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign Country)
Estonia Date of Dis...
(Month, Day, Yea 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Year, 1 🛛 M 2 🗆 F Sept. Yrs Director N/AUsual Residence of Decedent 28a-f shov 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any ence. 10b. County 10c. City, Town or Location 10a. State Director 1 Yes 2 □ No Baltimore Maryland N/A10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21215 4420 Evamay Road Apt.10 Estonia Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: 3 Nidowed 4 Divorced White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Grocery Store Maintenance Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ Galina unknown Gavriil Evtioukhov 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4420 Evamay Road Apt. 1C, Batltimore, Maryland 21215 Natalia Vassiltova/ Friend Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition March Date 5 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 2010 Metro Crematory, Inc. 22. Name and Address of Facilit Cremation Society of Maryland, Inc. 21. Signature of Funeral Service Licens Amanda Heaston 199 Frederick Road, Baltimore, Maryland 21228 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Days Physician/ Due to (or as a consequence of): Medical resulting in death) Examiner Days Iden caranoma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to for as a consequence of been signed by the attending physician and should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Day 5 Other (specify) g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown within 24 hours after death.

To the Funeral Director: After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 No 1 ☐ Yes 2 ☑ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) completed filled in by the funeral director, 2 No Certificate: To 1 🗌 Yes 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) K. Kusuma M.D KES-000 March 01,2010

State Registrar

Wioukhov

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SINAI

HOSPITAL OF

BALTIMORE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KUSUMA KANAPARTHI

MAR 09

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		- For State Registrar		ertificate of			Reg. No.	2010	0691	
Physicia edical Examin	-	1. Decedent's Name (First, Middle, Last John Dec	amp	Elder		2. Date of De Month March 3,	Day	Year	3. Time of Death 2241 hrs	
		4a. Facility Name (if not institution, give Johns Hopkins Bayview M	street and number)		Bb. City, Town, or Location Baltimore			ounty of Death	1	
Funeral Director			7. Age (In yrs.	. last birthday) 61 Yrs.	If Under 1 Year If Un Months Days Hou		,	Foreig	thplace (State or gn ^{untry)} Maryla	
w any	Ī	Usual Residence of Decedent  10a. State 10b. County		ty, Town or Locati					10d. Inside City Limits 1 Yes 2 X No	
with the Maryland ns 23a or 28a-f show be notified at once.	ま	Maryland Baltim	ore	Dundal	10f. Zip Code		10g. Citize	n of What Cou		
with the l ns 23a or be notifie		8 Patapsco Avenue	12. Was Decedent Ever in		21222 s Decedent of Hispanic O		lo- 14	USA  14. Race - American Indian, Black,		
fter death	y Funeral	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?  1 Yes 2 X No If Yes, Give Year or Dates:		es, specify Cuban, Mexica Yes 2 No specia		S	White, etc. pecify:Whit	e	
2 hour	eted by	15. Decedent's Education (Specify on Elementary/Secondary (0-12)		16a. Deceden during mo	16b. Kin	d of Business/	Industry			
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Completed	12 years 17. Father's Name (First, Middle, Last)	6 years	Se	lf Employed 18.Moth	F Employed Engineering  18.Mother's Name (First, Middle, Maiden Surname)  DeCamp Farson  ddress (Street and Number or Rural Route Number, City or Town, State, Zip C				
ID 21215 2 should be filed and Mental Hy 27 is marked of matic event, th	<u>a</u> [	John D. Elder Jr.	voe Print )	19b. Mailing						
MD nd 2 sho alth and alth and a 27 is			Michaeleen Malone	life Partne	r 8 Pat	apsco Avenue	e, Dundalk,	Maryl		222
Baltimore, MD 2121 permit. Pages I and 2 should be fil Department of Health and Mental I Important: If item 27 is marked injury or other traumatic event.		1 Burial 2 Cremation 3 4 Donation 5 Other Specify:	Removal from State B	crematory or oth ayview C	er place) rematory	March 8, 2010	Bal	timore,	Maryland	
	Н	21 Signature of Funeral Service Licent 21 A D D D D D D D D D D D D D D D D D D	onnelly	/ Co	ame and Address of Faci nnelly Fune 10 Sollers	ral Home Of Point Road,	Dunda Dunda	alk,P.A	21222	
Physician \ /Medical Examiner		failure. List only one suse on ea Immediate Cause (Final disease a.	ch line. Cirrhosis of the Liver		e mode or dying, such as	odique or respiratory a	11031, 311001	, or riour	Between Onset and Death	
	_	Sequentially list conditions, b.	Due to (or as a consequence Chronic Alcoholism Due to (or as a consequence							
n :	Medical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a consequence							
e executer cian and rial - trans	dical E	d. UNPENDED	AMENDED							
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown	23c. If yes, outcome of pre 1 Live birth 4 Pregnant at time of o	2 Fe	al death 3 Ecto	pic pregnancy		Date of delivery	y Day Year	
P.O. Bes that the digned by the	<u>a</u>	Part II. Other significant conditions		t resulting in the u	nderlying cause given in		tobacco us		the cause of death?	
Division of Vital Records, P Isl or Attending Physician: The law requires is after death.  a) Director: After this certificate has been sign led in by the funeral director, page 2 should be to	Completed					pen	s an opsy formed?		topsy findings available completion of cause of es 2 No	
ician: The scertificate	Be C	25. Was case referred to medical examiner?	ospital: 1 Innationt 2		- IOthor	th (Check only one)	1			
n of Viding Physi	의	1 Yes 2 No 27. Manner of Death	28a. Date of Injury (Month, Day, Year)	✓ ER/Outpatient 28b. Time of It			Residence how injury			
ision Attendin ar death. rector: A	cation	1 Natural 5 Pending Investigation	on 28e Place of Injury - At	home farm stree	1 Yes 2 at, factory, office building,		(Street and	Number or Ru	ral Route Number, City	
Divis	Certification:	3 Suicide 6 Could not to determined	(Specify)			or Town,	State)			
To the Hos within 24 h To the Fur completely	29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as state (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the and manner stated.  29b. Signature and title of certifier 29d. Date signed (Moo									
	Ž	29b. Signature and title of certifier	te signed <i>(M</i> o. 14, 2010	nth, Day, Year)						
		30. Name and address of person who of Victor Weedn MD JD As	completed cause of death (Ite		enn Street, Baltimo	ore, MD 21201	I			
	L	31. Date filed (Month, Cary 2010	32. Registrar's Sign	ature bank	-					

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Jaivant Edwards 6:30 A M March 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1342 Atwood Rd. Montgomery Silver Spring 9. Birthplace (State or Foreign 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) Funeral Days Country) India 1**X** M 2 □ F Months Hours Min March 26.1934 75 Yrs Director 310-48-7690 Usual Residence of Decedent 28a-f shov 10a. State 10b. County or than "natural", or items 23a or 28a-f sho the Medical Exminer must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Silver Spring Montgomery 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20906 1342 Atwood Rd. United States death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 72 hours after If Yes, Give Year or Dates 1 Yes 2 XNo Specify: Specify: Asian Indian Completed 3 Widowed 4XXDivorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event the and injury or other traumatic. Elementary/Seconday (0-12) College (1-4 or 5+) Professor Higher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Edwards Seth Jason Doris Mary Bernard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Premala Brewster-Wilson/ Sister 1342 Atwood Rd., Silver Spring, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Ft. Lincoln Cemetery 3/6/2010 Bladensburg, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Light M00382 22 Name and Address of Facility Rapp Funeral and Cremation Services tolle & Lokur 933 Gist Ave., Silver Spring, MD 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dving, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. if any, reading to immediat cause. Enter Underlying Due to for as a consequence on Examir Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): burialattending physician for use as the buria Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Other (specify) Pregnant at time of death signed by the a Id be detached f 1 ☐ Yes ∠ ☐ 9 ☐ Unknown a  $\square$  Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed peen Were autopsy findings available prior to completion of cause of 24a, Was an cate has t page 2 s autopsy death? After this certificate Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? injury 1 Natural 5 Pending vithin 24 hours after death.

o the Funeral Director; Aformpleted filled in by the fu 2 No Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ☐ Homicide determined Medical Lectifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within To the comple 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 53 2010 MARCI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A

State Registrar 7758 WISCONSIN AVE

32. Registrar's Signature

M.D

31. Date filed (Month, Day, Year)

0 9 201

BETHESOA MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month EDD ELEN **Medical** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Tate Hospice House Linthicum Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗽 Days (Month, Day, Hours Months Min. Country) Director 095-14-3689 88 Sept. 14717 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Anne Arundel Linthicum 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 432 Hillview Drive Apt. 101 21090 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 X Married Š Baltimore, Maryland 21215-0036 1 Yes 2 No White ould be filed within 72 hours aft id Mental Hygiene. marked other than "natural", 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Telephone Operator Communications Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) uth and Mental h ည Roosevelt A. George permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic Mary Herrick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Donald K. Eddy/Husband 432 Hillview Drive Apt. 101 Linthicum MD 21090 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State March Pate 9 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 2010 Glen Burnie, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Singleton Funeral & Cremation Services PA 1 2nd Ave. SW Glen Burnie, MD 21061 an 23a. Part 1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Pnysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of) physician and the burial-trans Due to (or as a consequence of) Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 the attending p use as t IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Year Day detached 9 I Inknown certificate has been signed by rector, page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 hknown Completed 24b. Were autopsy findings available 24a. Was an Was an autopsy performed To the Hospital or Attending Physician: The law prior to completion of cause of death? 2 🗆 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Hospital 1 Tyes 2 **D** ျဉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signatule and title of certif License number 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day,

State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 19b per inf g901 3-12-10 vt.
State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2010 Month **Physician** March 7 5:33 PM CAROLYN DREWRY FERGUSON EISENHUT /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Baltimore County OAK CREST VILLAGE RENIASSANCE GRDNS Parkville 8. Date of Birth June 18, 1930 Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🕅 F Months Days Hours Min. Mary Land 218-26-6223 Director Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f si any injury or other traumatic event, the Medical Examinar must be notified Director 1 ☐Yes 2 No Parkville Maryland Baltimore County 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21234 8800 Walther Blvd USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Ye ar or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 Never Married 2 Married Maryland 21215-0036 1 ☐Yes 2 X No Specify: ģ Specify: 3 ₩ Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Banking Corporation 2+ Mortgage Bank Officier 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Vernon Drewry Ferguson Marguerite Schwartz 2 Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mr. Robert W. Eisenhut (Son <del>20</del> Gateswood Road, Lutherville, Maryland 21093 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 1 Burial 2 □ Cremation 3 □ Removal from State Dulaney Valley Mem Grdns 3/11/10 Timonium, Maryland 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Livensee

Martin D. Lawson MITCHELL WIEDEFELD FUNERAL HOME, INC 6500 York Road, Baltimore, Maryland 21093 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Atheroschrosis disease or condition resulting in death) /Medical Due to (or as a consequence of). **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) burial-trar Due to (or as a consequence of): physician at the burial O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ CVA, HTN, Alzheimers 1 Yes PNo 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performe 2 🗆 No Division of Vital 1 □Yes P No 1 ☐ Yes ospital or Attending Physician: hours after death. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Yes ₽ No Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 5 Pending investigation Natural 2 ☐ Accident 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) þ determined 4 Homicide 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 hor To the Fune completely fi Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Wealle R171944 CARPINSON 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Micheelle G. Harrison CRNP NSN 8800 Wolfher Blvd, Packville, MD, 21234 31. Date filed (Month, Day, Year)
MAR 09 20 State Registrar

DHMH 17 Rev 1/2001

3

GRULY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. / 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ □2010 March 7. James Fitzgerald W. 11:20 pm Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 1 Baratra Court Apt 203 Timonium Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth Funeral 1 M 2 F Days Jumenth, 1767, Year 935 212-32-7851 74 Mary and **Director** Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director Baltimore 1 Tes 2 No Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1 Baratra Court, Apt 203 21093 U.S.A. 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? þ Maryland 21215-0036 1 ☐ Yes 2 No Specify If Yes, Give Year or Dates Specify: White 3 Nidowed 4 □ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nould be filed within 72 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Production Manager Defense Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Fitzgerald Angeline T. Bish 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 sl Health a James R. Fitzgerald-son 20 Merrion Court, Timonium, MD 21093 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Dulaney Valley 3/11/10 Timonium, MD 21. Signature of Funeral Service Licensee William 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Dau G. 1050 York Rd., Towson, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to r as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease of injure that initiated events resulting in death) Last attending physician and for use as the burial-transi Due to (or as a consequence of) Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, cate has been sig page 2 should b 2 No 3 Probably 4 Unknown Completed 24a. Was an Were autopsy findings available autopsy prior to completion of cause of death? performed? this certificate 1 Yes 2 No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medica Certificate: To Be 26. Place of Death (Check only one) examiner? 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 27. Manner of Dea h 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of Injury at 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide Medical 29a. Certifier Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ess of person who completed cause of death (Item 23a) (Type, Print) 

State

Registrar

MAR 09

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death edent's Name (First, Middle, Last) 2. Date of Death Physician/ eeney 00 PM MARCH 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death County of Death ANNE Baltimore Washinatan Medical Center 13 Glen uznie . Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 8. Date of Birth 9. Birthplace (State or Foreign 1 ☑ M 2 ☐ F Days Months Hours Min. NOV 25 Year) 944 Country) 219-44-9346 Director 65 MD Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🔽 No Anne Arundel Pasadena Maryland 10e. Street and Numbe 10f. Zin Code 10g. Citizen of What Country? Funeral 309 North Carolina Avenue 21122 USA than "natural", or items 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces Black, White, etc 1 Never Married 2 Married Completed by Yes 2 No If Yes, Give 1 ☐ Yes 2 ☑ No Specify: 3 Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Anne Arundel County Elementary/Seconday (0-12) College (1-4 or 5+) should be filed with h and Mental Hygien 7 is marked other th Public Schools 12 Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Alfred Feeney Grace Redmond permit. Page 1 and 2 should be Department of Health and Menr Important: If item 27 is marke any injury or other traumatic. once. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Pasadena, MD 21122 19a. Informant's Name/Relationship (Type, Print) Diane S. Feeney (spouse) 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Buria! 2 🔀 Cremation 3 ☐ Removal from State 09 March 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. Baltimore, Maryland 2010 21. Signature of Funeral Service Licens 22. Name and Address of Facility Stallings Funeral Home, P.A. Mountain Road, Pasadena, MD 21122 23a. Part . Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Physician/ Onset and Death Neutropenic disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner remothera Sequentially list conditions, if any, leading to immediate Due to for as a consequence of if any, leading to immedicause. Enter Underlying Cause (Disease or iinjury that initiated events the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Day Month Year 1 Yes 2 No the i 9 Unknown ed by t detach s been signed by should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown carcinoma 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has t autopsy perform death? After this certificate 2 No Yes 25 25. Was case referred to medical examiner? Be director, 26. Place of Death (Check only one) 1 Yes 2 10 Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending ithin 24 hours after death.

the Funeral Director: At ompleted filled in by the fu Accident
Suicide 1 Yes 2 🗌 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the basis of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2

To the F

complete only one 29b. Signatur 29d. Date signed (Month. Dav. Year) 2010 derson who completed cause of death (Item 23a) (Type, Print) 301 Glen Burnie, MD 21061 Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

MAR 09

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March Physician/ 7 010 0635 AM Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Bayview Medical Honkins 3altimoire N/A If Under 1 Year If Under 24 Hrs Social Security Numbe 6. Sex 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 🗆 F Months Hours Min. 08^{(M}04th,1¹942^{ear)} Maryland Director 220-38-5692 67 Usual Residence of Decedent 23a or 28a-f shov 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 29 N. Kresson Street 21224 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 Married X Yes Yes, Give 2 No Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Specify: 3 Divorced 4 X Divorced Year or Dates. Vietnam White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Chauffeur Railroad Industry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Wilson Fitzpatrick, Sr. Rosa L. Bell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Fitzpatrick - Son 1540 Alconbury Road Essex, Maryland 21221 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Moreland Memorial Park 03-10-2010 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21. Signatur of meral Service Licens 22. Name and Address of Facility 5305 Harford Road Leonard J. Ruck, Inc. Baltimore, Maryland 21214 23a. Part 1. Enter the sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Immediate Cause (Final Interval Between Onset and Death Physician disease or condition resulting in death) Medical Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury s been signed by the attending physician and should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ 1 Yes 2 No 3 Probably 4 Unknown Completed is certificate has been director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy performe 25. Was case referred to medical examiner?
1 ☐ Yes 2 🗷 No Be 26. Place of Death (Check only one) n 24 hours after deau.. he Funeral Director: After this ce heleted filled in by the funeral direct Other: မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DCA 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural injury work? 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined 29a. Certifier Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) 29b. Signature and title of cortifier 29c. License number

State Registrar

DHMH 17 Rev 7/2009

30. Name and address of person who completed

atnik

Hemmina

4940 Eastern Avenue Baltimore MD 21224

cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registral Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 3:00 P 28, 2010 Lorenzo Davis Franklin Feb. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Prince Georges 13011 Chalfont Avenue Fort Washington 8. Date of Birth (Month, Day, Aug. 22, If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** Days Hours 1 M 2 □ F Months Vĭrginia 1949 60 Aug. Director 228-74-6164 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 1- Yes 2 No Fort Washington Director MD Prince Georges 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20744 USA 13011 Chalfont Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ 1969 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status Black White etc. 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1971 Specify. þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Concrete Finisher Home Construction 9 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James Clifton Alice Thompson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 13011 Chalfont Avenue, Fort Washington, MD 20744 Geraldine Franklin - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place)
Culpeper National 20c. Location - City or Town, State 20a. Method of Disposition 3 Removal from State 1 ☑ Burial 2 ☐ Cremation Mar.5,2010 Culpeper, VA 4 Donation 5 Other (Specify) Cemetery 22. Name and Address of Facility W. C. Thompson Funeral 21. Signature of Juneral Service Lipinsee 22701 503-7 North Main Street, Culpeper, VA Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner and (or as a consequence of): physician anema Physician/Medical the as IF FEMALE: use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy page performe certificate 25. Was case referred to medical examiner? funeral director. 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 2 After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Injury at Work? Medical Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No s after death. 2 Accident the 1 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

l in by t

The law requires that the death certificate be executed

Division or Vital Records, P.O.

or Attending Physician:

3altimore, Maryland 21215-0036

and manner stated.

1@Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

se of death (Item 23a) (Type, Print) person who completed ca 017011

32. Registrar's Signature

State Registrar

(Check only one)

31. Date filed (Month, Day,

within 24 hours a

To the Funeral Hospital

completely

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day PAULINE FOLEY MARCH 2010 8:35 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 1616 Prindle Drive Bel Air Harford Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, July 17 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Year) 1 □ M 2 🖾 F Months Days Hours 220-28-9531 Director 78 1931 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits show item 27 is marked other than "natural", or items 23a or 28a-f shor other traumatic event, the Profice Exp., are unst be notified at Director 1 ☐ Yes 2 No Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3 Overbrook Lane 21014 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces?
1 □Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 💆 No If Yes Give Specify. ģ Specify: 3 ₩ Widowed 4 Divorced Year or Dates: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Library Processing Manager Public Schools permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked other any Injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ္ Harry Hammers Beeman Carrie Elizabeth Kifer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tim Saneman 1616 Prindle Drive, Bel Air, MD 21015 lethod of Disposition 20b. Place of Disposition (Name of chemeter) crematory or other place) 20c. Location - City or Town, State 2 Crer aul's Lut. Cem. : 3-9-10 Aberdeen, Maryland Accomas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, MD 21009 ons that caused the death. To not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death t1. Into the or soor s ck, or heart failure. List o Immediate Cause (Final **Physician** disease (r condition resulting (death) di menta /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner death certificate be executed and Due to (or as a consequence of): physician the burial Physician/Medical signed by the attending I IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Hunknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 WNo certificate 1 ☐Yes 2 ☐No 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Son S 1∐ Yes Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mann of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Residence 5 Pending investigation 1 atural 1 □Yes 2 □ No Accident

Box 68760, o ٣. Records, of Vital Hospital or Attending Physician: To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir Division

title of certifier 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 602 SATWOOD, BELAIR MD - 21014 Suite 100. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

ORIGINAL

28f. Location (Street and Number or Rural Route Number, City or Town, State)

6 □ Could not be

3 Suicide

29a. Certifier

4 ☐ Homicide

(Check only one)

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Nonth 3 Physician/ 6.55 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Arno1d 806 Buena Vista Avenue Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Sex, **Funeral** Dec 21 . Year 94<u>9</u> Days Hours Tennessee 60 337-44-6168 Director Usual Residence of Decedent "natural", or Items 23a or 28a-f show edical Examiner must be notified at 10b. County 10d. Inside City Limits 10c. City, Town or Location 10a, State 72 hours after death with the Maryland Director 1 ☐ Yes 2 🔀 No Arno1d MD Anne Arundel 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 21012 USA 806 Buena Vista Avenue 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2X Married Completed by Baltimore, Maryland 21215-0036 white ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical once. 16a. Decedent's Usual Occupation 15. Decedent's Education 16b Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) construction general supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Annie Catherine Burns Henry Alfred Forbus b. Mailing Address (Street and Number or Rural Route Number, Çity or Town, State, Zip Code) 806 buena Vista AVenue Arnold, MD 21012 19a. Informant's Name/Relationship (Type, Print) Terri Forbus/spouse 20c. Location - City or Town, State 20a, Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 Other (Specify) 21. Signatur uneral Service State Anatomy Board 655 W. Baltimore Street Raltimore. MD. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between O set and Death 23a. Part Immediate Cause (Final Pnysician/ disease or diti resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine Due to (or as a consequence oi). if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month 5 Other (specify) Pregnant at time of death signed by the a d be detached f g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 nknown cate has been sig , page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 Yes 2 No Yes 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ည within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral director. 28a. Date of injury 28b. Time of 28c. Injury at work? 27. Manner of Death 28d. Describe how injury occurred Certificate: Natural (Month, Day, Year) injury 5 Pending 1 Yes 2 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined building, etc. (Specify) City or Town, State) Medical Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 ☐ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signative and title of certif 29d. Date signed (Month) Day, Year) 29c. License number

Registrar

31. Date filed (Month, Day,

se of death (Item 23a) (Type, Rrint

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 2010 06925

		1- For State Registrar	Certificate of		i wichtai		2 U 1	0 0092			
Physic rdical Exam	ian/ nine	Billy Jerome Floyd				2. Date of Dea Month February 2	eg. No. th Day Year 20, 2010	3. Time of Death 0226 hrs			
		4a. Facility Name (if not institution, give street and number) 600 block W. Patapsco Avenue		4b. City, Town, o	or Location of De	ath	4c. County of Dea				
Funera Director		1 M 2 F	yrs. last birthday) 55 _{Yr}	If Under 1 Ye Months Da		Irs. 8. Date of Birlin. June 3		Birthplace (State or unkering)			
d bow any		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location  MD Anne Arundel Glen Burnie									
he Marylan or 28a-f sl	Director	10e. Street and Number 416 Pamela Road #A		10f. Zip Code	21061	10	Og. Citizen of What Co	1 Yes 2 No			
r death with the Maryland or items 23a or 28a-f show any must be notified at once.	Funeral		unk If	as Decedent of Hi res, specify Cuba	ispanic Origin? (	Specify Yes or No- to Rican, etc.)	USA 14. Race - Ame White, etc.	erican Indian, Black,			
2 hours after d "natural", or	à	3 Widowed 4 Divorced If Yes, Give Year or Dates:	No 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Yes 2 Nont's Usual Occupa	o specify:	f work done	Specify: b.	lack			
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e, MD 2 I and 2 shoul Health and M item 27 is m	To	19a. Informant's Name/Relationship (Type, Print )  O.C.M.E.	111	Penn St	reet Ral		ober, City or Town, State	e, Zip Code)			
imore Pages 1 ment of F tant: If i		1 Burial 2 Cremation 3 Removal from State	20b. Place of Dispos crematory or ot	sition (Name of ce	metery,	Date	20c. Location - City o	r Town, State			
		21. Signature of Funeral Strice Licensee Ronald S. Wade, heet	tor	Name and Address tate Ana altimore	tomy Boa	ard 655 W	. Baltimro	e Street			
Physician /Medical Examiner		23a. Part I. Enter the disease, or complications that caused the defailure. List only one cause on each line.  Immediate Cause (Final disease a. <b>Head injurie</b> or condition resulting in death)	es	he mode of dying,	such as cardiac	or respiratory arres	st, shock, or heart	Approximate Interval Between Onset and Death			
	Jer	Sequentially list conditions, if any, leading to immediate  Due to (or as a consequent or least a consequent o									
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Records, P.O. Box 68760, The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - transi	sician/	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown	2 Fet	tal death 3 [ ner (Specify)	Ectopic pregn		23d. Date of deliver Month	y Day Year			
i, P.O. B	[ق	Part II. Other significant conditions contributing to death but no	ot resulting in the u	nderlying cause g	iven in Part I.		acco use contribute to				
Division of Vital Records, tal or Attending Physician: The law requirers after death.  al Director: After this certificate has been sited in by the funeral director, page 2 should be	ompleted					24a. Was an autopsy	prior to d	utopsy findings available completion of cause of			
ital Recician: The lactor, page	O L	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2			of Death (Check	perform 1 Yes 2 only one)	ed? death? No 1 Ye	es 2 No			
n of Viding Physi ding Physi h. After this funeral dir	on: To	27. Manner of Death  28a. Date of Injury (Month, Day, Year)	ER/Outpatient 28b Time of In	jury 28c. Injur	y at Work?	28d. Describe ho	esidence 6 🗸 Other w injury occurred	t Scene			
Division of Vital I Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certificatory tely filled in by the funeral director.	Certification;	2 Accident Investigation Fd 2/20/10 3 Suicide 6 X Could not be 28e. Place of Injury - A	Fd 2:15 at home, farm, street nd: stree	t, factory, office bu	es 2 X No uilding, etc.	28f. Location (Str. or Town, Stat	eet and Number or Ru	ral Route Number, City of W. Pataps			
To the Hospital within 24 hours To the Funeral completely filled	ल्	29a Certifier (Check only one) 2 V Medical Examiner: On the basis of examination	ledge, death occurri n and/or investigation	ed at the time, dat	te and place, and death occurred a	due to the cause(	Clmore, N	<u> </u>			
F × F S	¥ ₹	29b. Signature and title of certifier		29c. License	number	2	9d. Date signed (Mor	nth, Day, Year)			
	;	30. Name and address of person who completed cause of death (It Ling Li, MD Assistant Medical Examiner 1	em 23a) 11 Penn Street								
Sta Registr	_	31. Date filed (Month, Day, Year)		1							

Funera Directo

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division or Vital Records, P.O. Box 68760,

	٠	State Registrar				Cei	rtificat	e of L	Death		-	Reg. I	No.20	10	069	26	
		1. Decedent's Name	e (First, Middle	, Last)							2. Date of De		Jav	Year	3. Time of D	eath	
cian dical		Jane Fis	sher								Month March	7,	2010	rear	7:30A	М	
iner		4a. Facility Name (I	f not institution	, give street and nu	nber)		4b. City, Town, or Location of Death							4c. County of Death			
	J	MD Masor	nic Hom	es			Cocl	ceysv	ville				Bal	timor	:e		
al		<ol><li>Social Security N</li></ol>	lumber	6. Sex	7. Age (In yrs. I	,,	If Under Months	1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Bir (Month, Da	v. Yea	ar)	9. Birth	place (State or	Foreign	
r		291-05-5		1□ M 2□ F	95	Yrs.			1.00.0		July 2	19	14	I	ndiana		
		Usual Residence of 10a. State	Decedent 10b. County		100 Cit	, Town or Lo	ontion								10d. Inside City	Limite	
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150		MD	I	Imore	CO	ckeysv										Z	
Director		300 Inte		nal Circl	e		10f. Zip		.030			10g. Citizen of What Country?  USA					
Funeral	3	11. Marital Status		12. Was Dec	edent Ever in U.	S. 13. \	Was Dece	dent of Hi	ispanic Orig	jin? (Spe	ecify Yes or No Rican, etc.)	)-	14. Rac	e - Americ	can Indian,		
		1 Never Marri	ied 2□ Marri	ed 1 ☐ Yes	2 <b>V</b> ] No					, Puerto	Rican, etc.)		Blac	ck, White,			
2	7	3X Widowed	4 Divorced	If Yes, Gir Year or D	ve ates:		1 ☐ Yes	SXT NO	Specify:			Specify: white					
Completed by		(Spor	15. Decedent	's Education at grade completed)		16a. Deced	dent's Usu	al Occupa	ation	of worki	ina	16b	Kind of B	usiness/In	dustry		
2		Elementary/Seco		College (	I-4or 5+)	life.	DO NOT u	se retired	during most ()	UI WOIKI	ny						
٦		12				Но	memal	cer				Ow	n Hoi	ne			
a B		17. Father's Name	(First, Middle, i	Last)							(First, Middle			ne)			
2		William	Murray	Castor					Dor	othy	y Patte	rsc	n				
		19a. Informant's Na Richard		_{nip (Type. Print)} isher/son			-				al Route Numb New M				,		
		20a. Method of Disp	,	3 □Removal from		lace of Dispo emetery, crei	7030 Fox Chase Rd., New Market, MD 21774  Disposition (Name of corematory or other place)  Date 20c. Location - City or Town, State										
1		4 □ Donation  21. Signature of Fu	5 Other (Sp	pecify)	Ch				1 Gar		s3/15/1	0_	Punta	a Gor	da, FL		
0110		Michae	ON	Dagle		10	emmor W. I	Fun	ieral ia Rd	Home	e of Du Timoniu	lar m,	MD 2	alley 1093	, Inc.		
	1	23a. Part1. Enter to shock, or hea	he disease,	only one cause on e	aused the death	n. Do not ent	er the mod	de of dyin	g, such as	cardiac o	or respiratory a	rrest,			Approximate Interval Betw	een	
n	1	Immediate Cause (	(Final	A	ITTE	R	ESF	IRA	-MR	4	FAI	LL	IR C		Onset and De	eath	
	1	resulting in death)		Due to	or as a consequ	uence of):			,,,,						710-17		
r	1	Compostially list on	aditions	END.	STAGE	CHR	DIVIC	OBS	STRUC	TIVE	PULMU	NA	ey D	SUSE	· YE	14125	
E de		Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or that initiated events	nmediate erlying	Due to	(or as a consequ	uence of):			3.5		*				(3)		
Examiner	i	Cause (Disease or that initiated events	injury	С													
		resulting in death) l	Lasi	Due to	(or as a consequ	uence of):											
Medical				d													
Med	1	IF FEMALE:															
		23b. Was deceden in the past 12		23c. If yes, ou 1□Live t	tcome pf pregna pirth 2 □ Feta	ncy I death 3	∃Ectopic p	regnancy						te of deliv			
Completed by Physician		1 □ Yes 2	No	4□Pregr 9□Unkn	nant at time of do	eath 5	Other (sp	pecify)					IVIC	onth	Day Ye	ear	
삼		9 Unknown											!				
2		C	Por Lant	ons contributing to d		-	nderlying o	ause give	en in Part I.		11	5			the cause of de		
Pa		CONGE	>11VG	176414	FAIL	uice	<del>, c</del>	14101	110 my	OPH	7/1	Yes	2 No	3 ☐ Prol	bably 4 ∏Ur	nknown	
90		11/6	LUNG	CARCI	NOMA						24a. Was		24b.	Were auto	opsy findings av	vailable	
											perfo	rmed 2 X	? No	death? 1 ☐ Yes	2□ No	250 01	
Be	AU-	25. Was case refer examiner?	rred to medical						26. Place	of Death	Check only o	<del></del>					
100		1 Yes 2	No	Hospital: 1	Inpatient 2	ER/Outpatier	nt 3 🗆 DC	Othe	er: 4 Nu	rsing Ho	me 5 Resi	dence	6 □Oth	ner (Speci	fy)		
2		27. Manner of Deat Natural		28a. Date	of Injury th, Day Year)	28b. Time o	f 2	28c. Injun Work			28d. Describe						
atic		2 Accident	5 ☐ Pending investig	ation	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,,	М		Yes 2 □ N	No							
Certification:		3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could n determi	not be ined 28e. Place build	of injury - At ho ing, etc. (Specif)	me, farm, str /)	eet, factor	y, office				(Street and Number or Rural Route Number, own, State)				er,	
		29a. Certifier	Certifyin	g Physician: To the	best of my kno	wledge, deat	h occurred	at the tin	ne, date an	d place	and due to the	Cause	e(s) and m	anner as s	stated	-	
Medical		(Check only one)	Medical	Examiner: On the b	asis of examina ner stated.	tion and/or in	vestigation	n, in my o	pinion, dea	th occur	red at the time,	date	and place,	and due t	o the cause(s)		
Ž		29b. Signature and	title of certifier	0/1	^		29	c. License	e number			29d.	Date signe	d (Mgnth,	Day, Year)		
	1	Koke	5 Ku	ValurA	W		1	)-	194	25			3/8	1/2	010		
		0 - 1	00	who completed caus	se of death (Item	23a) (Type,	Print)	Diai	Así	75	Rain	,a	. 01	1 11	0 7 1	7.1	
tate		31. Date filed (Mon		150 KD / 33	Registrar's Signa	tue	LIN.	VEN	MV	C -	1244	IN	OKE	171	) 41	201	
strar		K.	AK U 9	ZUTU CH	wer &	7. 40	A CO										

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Year Fitzgerald, Jr AM Leroy 2010 8:00 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Square -DSECIONA Yanklin Hosoital If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number \ 218-36-2687 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** 1 🛛 M 2 🗆 F Days Hours Min. Manth, 9ay, Year 39 MD **Director** 70 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director 1 Yes 2 No Baltimore MD na 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5471 Princess Drive 21237 S 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married δ Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 X No Specify: Specify: "natural" Completed 3 Widowed 4 Divorced Year or Dates is marked other than "natur aumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Mental Hygiene. Disabled Disabled 12 grade 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) ည Lois Adams Leroy Fitzgerald, 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5471 Princess Drive Rosedale, MD 21237 permit. Page 1 and 2 sh Department of Health ar Important; If item 27 is any injury or other tra Catherine Fitzgerald-Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Surial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Memorial Pk 3-8-2010 Randallstown, MD 21. Signature of Fapr rai Service 22. Name and Address of Facility March East F/H MD 21202 1101 E.North Balto, Avenue 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician tatal MALLAND disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner ancreatic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ for in the past 12 months? Pregnant at time of death Yes 2 No 1 | Yes 2 L 9 | Unknown page 2 should be detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No s after death.

I Director: After this certificate in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 2 No မှ 1 Tyes 1 Inpatient 2 K ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 Yes 2 No 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 4 Homicide 28f. Location (Street and Number or Rural Route Number, completed filled in by determined building, etc. (Specify) City or Town, State) 24 hours a Funeral I Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Continuing Nurse Practiphers to the best of my knowledge, death occurred at the time, date and place, and due to the cause (s) and manner stated. (Check To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 Dr. NONO NOVELLO Franklin Square Drive Baltimore MD 21237

DHMH 17 Rev 7/2009

State Registrar

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month Day **Physician** 0320 M 06 2010 03 hu /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Harford Upper Chesapeake Medical Center Bel Air Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 6. Sex **Funeral** Hours Min. 1 M 2 ☐ F Months Days Yrs. 03/06/2010 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location death with the Maryland 10a. State Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Edgewood MD Harford 10g. Citizen of What Country? 10f, Zip Code 10e, Street and Number USA 21040 714 Rainbow Ct Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Black, White, etc. 11, Marital Status e filed within 72 hours after of Hygiene. I Hygiene. I other than "natural", or itel 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 No Specify Baltimore, Maryland 21215-0036 Completed by 3 Widowed 4 Divorced Year or Dates: 16h Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) n/a 18. Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) Be Pages 1 and 2 should be Derby Griffith Shane Griffith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Edgewood, MD 21040 714 Rainbow Ct Shane Griffith (Father) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐Removal from State 03-09-2010 Baltimore, MD Bayview Crematory 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Home of BelAir, 21. Signature of Funeral Service Licensee feele Inc 610 W. MacPhail Rd Bel Air, MD 21014 1112 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Extreme rematurit **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner death certificate be executed attending physician and I for use as the burial-trai Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 4□Pregnant at time of death 5 Other (specify) been signed by the a 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No After this certificate has funeral director, page 2 1∏ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Dipatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 No 1 🔲 Yes 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No M 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 4 ☐ Homicide Ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated. one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D61186 03,06,2010 Birhane

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3/0/2010

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GUHIHU, BOIL BO

State Registrar BITHANE OL 31. Date filed (Month, Day, Year)

OLJIRA
ny, Year) 32.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

500 UPPER CHESAPEAKE DRIVE,

BELAIRIND 2104

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Alfred Goodman		State of Maryland / Department of H 1-For State Certificate of D Registrar		ygiene _{Reg}	No 2010	06929
Physici Medical Exam		1. Decedent's Name (First, Middle,Last)		2. Date of Death Month	Day Year	3. Time of Death 0605 hrs
inculcul Exam	ilei	Alfred Douglass Goodman, Di.	City, Town, or Location of Death	March 4, 20	4c. County of Death	0000 1113
		3502 Woodbrook Avenue	altimore		N/A	
Funeral Director			Under 1 Year If Under 24Hrs Months Days Hours Min.	_	(MM/DD/YYYY) 9. Birt Foreig Ma	n
ķ		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
d now any		Maryland N/A Baltimor	re			1 Yes 2 No
taryland 28a-f show at once.	Director	10e. Street and Number 10	of. Zip Code	10g	. Citizen of What Coun	try?
hours after death with the Maryland natural", or items 23a or 28a-f sho Examiner must be notified at once		3502 Woodbrook Avenue  11. Marital Status 12. Was Decedent Ever in U.S. 13. Was De	21217		USA	n de Blad
eath w items ust be	Funeral	1 Never Married 2 Married Armed Forces? If Yes,	ecedent of Hispanic Origin? ( Sp specify Cuban, Mexican, Puerto		14. Race - Americ White, etc.	an Indian, Black,
after d	by Fi		s 2 No specify:		Specify: E	Black
hours natur Exami	ed t	during most of	Isual Occupation (Give kind of w of working life. DO NOT use retir		6b. Kind of Business/Ir	ndustry
5-0036 led within 72 hours at Eygiene. other than "natural the Medical Examin	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)  12th grade Unemp	ployed			
5-0C led wit Hygien other the M	S	17. Father's Name (First, Middle, Last)	18 Mother's Name			
21215-0036 nuld be filed within 7 Mental Hygiene. marked other than	Be	Alfred D. Goodman, Sr.  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Ad	Doroth			7.0
AD 2 sho 27 is mati	٩	Dorothea Goodman/Mother 3502 Wo	dress (Street and Number or Foodbrook Ave	Baltin	ore, Mary	and 21217
ore, No. 1 and Street International		20a. Method of Disposition  1  Burial 2 Cremation 3 Removal from State crematory or other process.	nlace)	22	20c. Location - City or	
Baltimore, permit. Pages 1 a Department of He Important: If ite		4 Donation 5 Other Specify: Baltimore	National cem			e,Maryland
Baltimo permit. Page Department of Important:	1	21. Signature of Funeral Service Licensee 22. Name	and Address of Facility Cha	tman-Ha	rris Fun	eralHome
./ Physician	7	23á. Part I. Enter the disease, or complications that caused the death. Do not enter the m	o reignerano	wii Ku E	<u>a.c.imore</u>	Approximate Interval
Medical Examiner		failure. List only one cause on each line.  Immediate Cause (Final disease a. Smoke Inhalation and Thermal injuries	8		- 3	Between Onset and Death
LXammer		or condition resulting in death)  Due to (or as a consequence of):				
	힐	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
	Examiner	Clisease or injury that initiated events resulting in death) Last				
executed an and al - transit	ă	d.				
50, te be executed sysician and burial - transit	edical	UNPENDED				
876( ifficate ng phy:	M/U	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal d	eath 3 Ectopic pregna	ncv	23d. Date of delivery  Month Di	ay Year
Box 6876 e death certificate the attending phyelf for use as the b	Physician/M	past 12 months?  4 Pregnant at time of death 5 Other	(Specify)		V)	
D.O. Box 6876 that the death certificate ned by the attending phy detached for use as the l	Phy	Part II. Other significant conditions contributing to death but not resulting in the unde	rlying cause given in Part I.	23e. Did toba	acco use contribute to the	he cause of death?
P.C ires that signed b	d by			1 Yes	2 No 3 Proba	ably 4 🗸 Unknown
ords v requires s been should	lete		-	24a. Was an autopsy		opsy findings available ompletion of cause of
Recol	Completed		_	perform 1 Yes 2	ed? death?	
of Vital Rec Jing Physician: The After this certificate funeral director, page	Bec	25 Was case referred to medical examiner? Hospital: 1 Inpatient 2 FR/Outpatient 3	26 Place of Death (Check of			
of Vi ing Physi After this uneral dir	유	1 V Yes 2 No 28a Date of Injury 28b. Time of Injury		g Home 5 Re	esidence 6 🗸 Other:	Scene
Division of Vital Records, P.O. rat or Attending Physician: The law requires that it is after death.  al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detacted.	ation	1 Natural 5 Pending FOUND: FOUND: Pounding Investigation Mar 4, 2010 FOUND: 0201 hrs		Victim of hous		
Divisi spital or Att nours after d neral Direct filled in by	Certification:	3 Suicide 6 Could not be determined (Specify) Townhouse / Rowhouse		or Town, Stat	eet and Number or Run e) k Avenue, Baltimore	
Division of Vital Records, P.O. Box 6876 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the t	Medical C	29a. Certifier (Check only one)  29a Medical Examiner: On the basis of examination and/or investigation, and manner stated.			•	
F 3 F 8	Μe	29b. Signature and title of certifier	2	9d. Date signed (Mon	th, Day, Year)	
$\mathbf{p}_{n}$		high. vs	O.C.M.E.		March 4, 2010	
JV		<ol> <li>Name and address of person who completed cause of death (Item 23a)</li> <li>Ling Li, MD Assistant Medical Examiner 111 Penn Street, E</li> </ol>	Baltimore, MD 21201			
Si Regis	ate	31. Date filed (Month, Day, Year)  32 Registrar's Signature	)			
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OCME 2006						

บ-01832 .lfred Goodman	Sr		r Print in Black Ir					jible.			
ined Goodinan		1- For State	of Maryland / Depa <i>Ce</i> a	rtificate of		i wentai n		2010	06930		
Physici	an/	Registrar  1. Decedent's Name (First, Middle, Last	)				2. Date of Deatl	g. No. n Day Year	3. Time of Death		
Medical Exami	ner	Alfred Douglas  4a. Facility Name (if not institution, give			4h Cit. Town as I	and a of Dank	March 4, 2	010 4c. County of Death	0700 hrs		
		3502 Woodbrook Aveue	street and number)		4b. City, Town, or L Baltimore	ocation of Death	1	N/A			
Funeral		5. Social Security Number 6. Sec	, ,	last birthday)	If Under 1 Year Months Days	If Under 24Hrs Hours Min		h (MM/DD/YYYY) 9. Birt			
Director		212-48-3497 1X	§M 2□F 61	Yrs		Tiodis Will	June	28, 1948co	Mayryland		
any		Usual Residence of Decedent  10a, State 10b, County	10c. City	, Town or Locat		<del></del>			10d. Inside City Limits		
daryland 28a-f show any <u>1 at once,</u>	ō	Maryland N/A		Baltin					1 X Yes 2 No		
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland lealth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f sho trammatic event, the Medical Examiner must be notified at once.	Director	10e. Street and Number 3502 Woodbrook	Avenue		10f. Zip Code 21 21	7		lg. Citizen of What Coun SA	try?		
with then s 23 and be noti	_	11. Marital Status	12. Was Decedent Ever in U		s Decedent of Hisp	anic Origin? ( S	pecify Yes or No-	14. Race - Americ	can Indian, Black,		
r death or iten	Funera	1 Never Married 2 Married	Armed Forces?  1 X Yes 2 No		es, specify Cuban,		Rican, etc.)	White, etc.	o ale		
ırs afte ural", miner	β	3 Widowed 4 Divorced  15. Decedent's Education (Specify on	If Yes, Give Year 1965-1 or Dates: ly highest grade completed)		Yes 2K No nt's Usual Occupation		work done	Specify: B1			
11215-0036 Id be filed within 72 hours after fental Hygiene. narked other than "natural", event, the Medical Examiner.	eted	Elementary/Secondary (0-12)	College (1-4 or 5+)	during m	ost of working life. I stant Ad	DO NOT use ret	ired)	Military	Order		
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21215-00; uld be filed with Mental Hygiene marked other t e event, the Med	4	Thomas Kelly			10		Goodmai				
21, hould be and Men is mar	70	19a. Informant's Name/Relationship (Ty	WITTE			and Number or	Rural Route Num	ber, City or Town, State,			
ages I and 2 shount of Health and Nit: If item 27 is nother traumatic		Dorothea Goodma  20a. Method of Disposition		3502 Place of Dispos	Woodbr Sition (Name of cem	cook Av	renue Ba	altimore, 1 20c. Location - City or	MD 21217 Town, State		
S E E E		20a. Method of Disposition  1 Paurial 2 Cremation 3 Cherrologies  4 Donation 5 Other Specify;	Removal from State	crematory or other.	herplace) Nation	al Cem	11/10		e,Maryland		
Baltimo permit. Page Department of Important: injury or oth		4 Donation 5 Other Specify: 21. Signature of Funeral Service License		22. N	Name and Address	of FacilityCha		arris Fun	· -		
			wis	52	240 Reis	tersto	wn Road	d Baltimo	re,MD21215		
Physician > /Medical		23a. Part I. Enter the disease, or compl failure. List only one cause on each		i. Do not enter t	ne mode or dying, s	uch as cardiac d	or respiratory arre	st, snock, or neart	Approximate Interval Between Onset and Death		
Examiner			Oue to (or as a consequence of	of):							
	Ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence of	of):							
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a consequence o		-100 - 10						
executed an and il - transit		α									
	dical	UNPENDED	AMENDED 19a, per	FH g90	1 3/9/10	TT					
8760 ificate ng phys	cian/Med	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of preg	nancy	etal death 3	Ectopic pregna	ancv	23d. Date of delivery Month D	ay Year		
ox 6 ath cerr	···	past 12 months?  1 Yes 2 No 9 Unknown	4 Pregnant at time of de	noth -	her (Specify)				,		
O. B. trhe de by the	Phy		9 Unknown contributing to death but not r	resulting in the u	underlying cause giv	ven in Part I.	23e. Did tol	bacco use contribute to t	he cause of death?		
ords, P.O. v requires that the s been signed by te	d by						1 Yes	2 No 3 Prob	ably 4 🗸 Unknown		
ords, w requires been should	Completed						24a. Was a autops	sy prior to o	opsy findings available ompletion of cause of		
F Vital Recor Physician: The law r r this certificate has b al director, page 2 sh	Som						perform		s 2 No		
/ital sician: is certif	Be	25. Was case referred to medical examiner?	ospital: 1 Inpatient 2	ER/Outpatient		of Death (Check		Residence 6 🗸 Other	Scene		
of V ing Phy After th funeral d	n: To	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of Injury	28b. Time of I			28d. Describe h	ow injury occurred	00010		
sion trendi death. ctor: /	atio	1 Natural 5 Pending 2 ✓ Accident Investigation		0201 hrs		es 2 🗸 No	Victim of hou				
Divis pital or At ours after d eral Direct filled in by	ertification:	3 Suicide 6 Could not be determined			-	ilding, etc.	or Town, St	treet and Number or Rui ate) ook Aveue, Baltimore.			
	ပ	(Oncon only	an: To the best of my knowled			e and place, and					
To the Hos within 24 h To the Fun	Medical	2	On the basis of examination a and manner stated.	and/or investiga			at the time, date a		• • • • • • • • • • • • • • • • • • • •		
	2	29b. Signature and title of certifier	NS		29c. License O.C.M			29d. Date signed (Mor March 4, 2010	itn, Day, Year)		
11		30. Name and address of person who c	completed cause of death (Iter	n 23a)				,			
/ V					et, Baltimore, M	/ID 21201					
St Regis	tate trar	31. Date filed (Month, Day, Year) NAR 0 9 2010	32. Registrar's Signat	ure park							
	_	MAIN A A SA									

10-01832

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 19a, per Fh g901 3/1//10 T1 State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Earle Joseph Gleason 2010 8:41 Medical March 4a. Facility Name (if not institution, give street and number) 4c. County of Death
Baltimore **Examiner** 4b. City, Town, or Location of Death Towson Center Gilchrist 8. Date of Birth

(Month, Day, Year)

June 14, 1946 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral 9. Birthplace (State or Foreign Min Days 1 XM 2 □ F Hours Marvland Director 213-50-7729 Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director Baltimore Baltimore MD 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8205 B Loch Raven Blvd. USA 2123 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ XNo
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. Black, White, etc. à 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: white "natural" Completed 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Johns Hopkins Elementary/Seconday (0-12) College (1-4 or 5+) Library Clerk 12 University Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fill Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve Mary Eleanor Bowersox Earle Joseph Gleason 19a. Informant's Name/Relationship (Type, Print) sister 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3419 Glenside Drive-Parkville, Maryland 21234 Geraldine Gleason-<del>daughter</del> Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🗆 Burial 2 🔀 Cremation 3 🗆 Removal from State tvans Funeral Charel Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) and Cremation-Belair 2010 Mak 22. Name and Address of Facility
Evans Funeral Chapel and Cremation Services
8800 Harford Road-Parkville, Maryland 21234 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition TOI Medical resulting in death) Due to (or as consequence of) **Examiner** Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Due to (or as a consequence of). Exami attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, Completed 2 🗌 No 3 NProbably 4 □ Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform this certificate 1 TYes 2 | No Yes 2 🛚 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6/10 Other (Specify) 2 No 1 Yes ဂ္ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After 1 X Natural 5 Pending 1 🗌 Yes 2 🗌 No Investigation within 24 hours after death

To the Funeral Director: / Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Reg State trar's Signature Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ^D2010 March 8, Genevieve L. Gould 2:45 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Gilchrist Hospice Towson Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign **Funeral** 1 M 2 屎 F Months Days Hours Min. May 11, Pay, Year 917 Virginia Director 92 212-03-6236 Usual Residence of Decedent or 28a-f shov 10a. State 10b. County filed within 72 hours after death with the Maryland "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Maryland Towson 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7925 York Road 21204 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. ģ 1 Never Married 2 Married Yes 2 No Yes, Give Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: 3 X Widowed 4 Divorced Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Receptionist C+P Phone Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic. George M. Lowman Elva Pauline Gill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ellen G. Morrison-Cousin 1 Wine Spring Garth Towson, Maryland, 21204 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State March 09, 1 Durial 2 Dremation 3 Removal from State Evans Funeral Chapel Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2010 22. Name and Address of Facility
Peaceful Alternatives Funeral & Cremation Center, P.A.
2325 York Road Timonium, Maryland 21093 21. Signature of Funeral Service Licensee Tiffany Cohn Part 1. Enter the disease, or complications that caused shock, or heart failule. List only one cause on each line or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between t and Death Immediate Cause (Final ոբhysician/ disease or condition Medical resulting in death) as a consequence of Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) sician and burial-transit Due to (or as a consequence of) resulting in death) Last attending physiciar Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 as the t IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? þ Month Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown Division of Vital Records, P.O. signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b Completed 1 Yes 2 No 3 Probably 4 Unknown should b 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? Yes 2 N death? 24 hours after death.

Funeral Director, After this certificate leted filled in by the funeral director, page 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \( \) Nursing Home 5 \( \) Residence 6 \( \) Other (Specify) ည 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending work' Investigation 6 Could not be 1 Tyes 2 🗌 No Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🖵 🗲 ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. сотретер Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 the the only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

LON

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

DHMH 17 Rev 7/2009

6

29c. License numbe

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			, 101	artment of Health and Mer <i>rtificate of Death</i>		iene eg. No.2010	06933
ı	Physici	an	1. Decedent's Name (First, Middle, Last)		Date of Deat Month	Day Year	3. Time of Death
	/Medic	cal	Bakrad Gharakhanian  4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	-rch	5 2010 4c. County of Death	3:50 P. M
	Examir	1er	1305 Sheridan Place Apt. C	Bel Air		Harford	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year   If Under 24 Hrs.   8	Date of Birth (Month, Day,	9. Birth	place (State or Foreign
	Director		494-04-0731 XX ^{M 2   F   91 Yrs.}	Fe	eb. 15	, 1919 Ira	
	land ow		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Lo	ocation			10d. Inside City Limits
	a-fsh	ctor	Maryland Harford Bel A	ir			1 □Yes 2 □ No
	or 28	Director	10e. Street and Number	10f. Zip Code	1	0g. Citizen of What Cou	ntry?
	s 23a		1305 Sheridan Place Apt. C	21014		United Stat	
	ter de	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married 2 □ Married 1 □ Yes 2√2 No	Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rica	y Yes or No- an, etc.)	14. Race - Amer Black, White	
3	iurs af	þ	3 ₩ Widowed 4 Divorced If Yes, Give Year or Dates:	1 □Yes 2010No Specify:		Specify <b>Arm</b> €	nian
1215-0036	be filed within 72 hours after death with the Maryland ttal Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Exer, fact, ust be reutified at	Completed	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	edent's Usual Occupation  e kind of work done during most of working		16b. Kind of Business/I	ndustry
	within ene. than	dmo	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)		- 13	
2	filed y	Be Co	12 5+ Mechan 17. Father's Name (First, Middle, Last)	uical Engineer Roughr 18. Mother's Name (Fil	neck irst, Middle, M	Oi L Maiden Surname)	-
lan I		To B	Manser Gharakhanian	Nanjan Gha	arakhai	nian	
Maryland 2	a is a		A.S.	ng Address (Street and Number or Rural Ro		•	p Code)
	s 1 and 2 of Health item 27		Jirar Gharakhanian / Son 1704  20a. Method of Disposition 20b. Place of Dispo	Globe Court Bel Air,	-	Land 21015 20c. Location - City or T	own State
Baltimore,	o ~ <del>-</del> =		1 Burial 2 Cremation 3 Removal from State Evans Fu	matory or 1 there place) el March 8,	,	•	
			21. Signatur of Funeral Service Licensee	2. Name and Address of Facility	F	orest Hill,	AW 27 HOLD
ă	permit. Departi Imports any Inji		Jan L. Ebass	ans Funeral Chapel & Newport Drive Forest	& Crema	ation Servi . Marvland	ce-BelAir 21050
			23a. Part 1. Enter the disease, or con pli ations that caused the death. Do not en shock, or heart failure. List only one cause on each line.				Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Embolus			One month
	/Medical Examiner		Due to (or as a consequence of):				
		ē	Sequentially list conditions, if any, leading to immediate cause and Underlying				
	cuted nd ansit	Examiner	Cause (Disease or injury that initiated events				
Š,	be executed ician and burial-transit		resulting in death) Last Due to (or as a consequence of):				
0 0 0 0 0	cate phys the	dical	d				
٥ X	sician: The law requires that the death certificate certificate been signed by the attending phys rector, page 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of deli	verv
. BOX	death e atte	iciai	in the past 12 months?  1	☐ Ectopic pregnancy ☐ Other (specify)		Month	Day Year
7. O	requires that the neen signed by th	hys	9 □ Unknown				
Š,	res th	þ	Part II. Other significant conditions contributing to death but not resulting in the L	inderlying cause given in Part I.		pacco use contribute to	
cord	been should	Completed					bably 4 2 Unknown
a)	The law ate has b	du			24a. Was ar autops perforn	y prior to c	opsy findings available ompletion of cause of
	an: Tl tifficate tor, pa		25. Was case referred to medical	26. Place of Death (Ci	1 □Yes 2	2 No 1 □ Yes	2 □No
	nding Physician: th. : After this certifica funeral director, p	To Be	examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie	Other:			ify)
n 0	ng Pt ofter th	L:uo	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury	of 28c. Injury at 28d. Work?		ow injury occurred	
<u>s</u>	ttendi death. tor: A	icati	2 Accident investigation	M 1 Tyes 2 No	Lagation (Ou		at De A. Monto
UNISION	l or Ai after o Direc	Certification:	4 ☐ Homicide   reet, ractory, office 28f.	City or Towr	reet and Number or Ru n, State)	ral Houte Number,	
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Medical C	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, dea				
	orthe	Mec	dia mamor stated.	29c. License number	2	9d. Date signed (Month	, Day, Year)
	->-0		Marle Ded out	435522	1	MARCH 8	2018
			30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)			
			MARK WILL 2 NORTH A	lenge Bel AIR	MA	YLAND.	21014
	Sta Registr		31. Date filed (Month, Day Year)  AAR 09 2010  Annual 32. Registrar's Signature	29c. License number  d 35522  Print)  Venue Bel AiR			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ M ARCH 2005PM MICHAEL 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death RAVEN COMMUNITY LIVING CONTER BALTIMORE 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🕅 M 2 □ F (Month, Day, Year Mar 21. Country) Months Days Hours Director 215-60-3397 55 Mar Pennsylvania Usual Residence of Decedent 28a-f shov 10b. County ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director MD Baltimore Parkville 1 ☐ Yes 2 🛣 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3118 Texas Avenue 21234 USA unk 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by 1 X Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. white Specify: 3 Widowed 4 Divorced 172-77 Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Page 1 and 2 should be filed within 72 nent of Health and Mental Hygiene.

ant: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) transportation 12 truck driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Zelda Mae Marwood Julius Eugene Gibson Sr 19a. Informant's Name/Relationship (Type, Print) 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4046 Sharilyn Drive Abingdon, MD 21009 Julius Gibson Jr/brother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of I Important: If ite any injury or ot once. 1 🔲 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 X Donation 5 ☐ Other Specify) Signature Funeral Service Licensee State Anatomy Board 655 W. Baltimore Street rector Raltimore. MD Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Sause (Final MAZIGNANT MEZANOMA Physician METASTATIC disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician Physician/Medical or Attending Physician: The law requires that the death certificate be Box 68760 as the l IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery should be detached for in the past 12 months? Month Pregnant at time of death 2 No 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ DISEASE Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? After this certificate 1 Yes 2 No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 1 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 5  $\square$  Pending within 24 hours after death. To the Funeral Director At 1 Yes 2 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Hospital 29a. Certifier 1 👱 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated the only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) millen 30272 MARCH 02, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THOMAS S. MILLER, MO 3900 LOCHPAVEN BOULEVARD

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) March Year **Physician** 7:00 A M Sarah Gray 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Hopkins Elder Plus Edgemere If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye July 30, Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday, **Funeral** Year) 1920 Months Days Hours 1 □ M 2 🔯 F 89 213-32-5647 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show ed other than "natural", or items 23a or 28a-f show event, it is Medical Examinar must be notified at 1 □Yes 2 ¬No Director Baltimore Edgemere 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21219 USA 2829 Lodge Farm Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ▼ No 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2√ No Specify: Yes. Give Specify: black þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: unk 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) housekeeper unk unk es 1 and 2 should be filed word Health and Mental Hygier item 27 is marked other the unk unk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2829 Lodge Farm Road Edgemere, MD Hopkins Elder Plus 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 【 Other (Specify) in state 21. Signature of Furnaral onald State Anatomy Board 655 W. Baltimore Street Licensee . Wade, Darector Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or con firm resulting in death)

a. 

Due to (or as a consequence of): Approximate Interval Between Onset and Death 2 **Physician** Dears /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician: The law requires that the death certificate be executed Exami To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 □Yes 2 X No 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be examiner? 1 ☐ Yes 2 No Other: 4 \(\sum \) Nursing Home \(5 \sum \) Residence \(6 \sum \)Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To e Hospital or Attending Ph 124 hours after death. e Funeral Director: After th 27. Manner of Death Assisted 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation Living 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospital within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State Registrar

DHMH 17 Rev 1/2001

Medical

31. Date filed (Month, Day, Year)

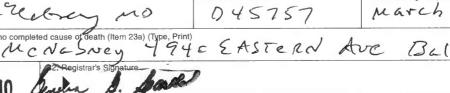
29b. Signature and title of certifier

Matthew

rea

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29a. Certifier



no

29c. License number

29d. Date signed (Month, Day, Year)

10-01877

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Donald Lee Graff State of Maryland / Department of Health and Mental Hygiene 2010 06936 1- For State Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ 0543 hrs Medical Examiner March 6, 2010 DONALD GRAFF 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Prince George's Greenbelt 7500 Block of Greenbelt Road If Under 1 Year If Under 24Hrs. 8. Date of 8irth(MM/DD/YYYY 9. 8irthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Months Director 10/23/1944 1 X M 2 F Country) I L 320-36-9348 65 Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 10a. State 1 Yes 2 X No or items 23a or 28a-f show must be notified at once, PRINCE GEORGE'S GREENBELT permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygöne.
Important: If item 27 is an arked other than "natural", or items 23a or 28a-f sht injury or other traumatic event, the Medical Examiner must be notified at once rector 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number USA 喜 20770 7 RESEARCH ROAD, 14 Race - American Indian, 8lack, Funeral 11, Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 X Never Married 2 Married 2 X No Yes 1 Yes 2 No specify: 3 Widowed 4 Divorced Yes, Give Year Specify: WHITE ģ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) FLECTRONICS ENGINEER 5+ 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) YABLONG GRAFF JANET Be 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ٩ 15635 WEST SHANGRI LA ROAD SURPRISE, AZ 85379 ELIZABETH ANDARI/NIECE 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) 1 X 8urial 2 Cremation 3 X Removal from State |03/11/2010 FOREST PARK, IL WALDHEIM CEMETERY 4 Donation 5 Other Specify: 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licer 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line nviedical Death a. Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed and Physician/Medical UNPENDED AMENDED attending physician or use as the burial -Box 68760, IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Fetal death 3 Ectopic pregnancy Month Day Year 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. ğ 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed' death? Yes 2 No 1 Yes 2 No After this certificate funeral director, page 26.Place of Death (Check only one) the Hospital or Attending Physician: 25. Was case referred to medical Division of Vital Hospital: 1 Inpatient 2 Other Nursing Home 5 Residence 6 Other: Scene ER/Outpatient 3 DOA 1 🗸 Yes 28a. Date of Injury (Month, Day Year) Mar 6, 2010 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury 27. Manner of Death Certification: Pedestrian struck by auto 0537 hrs 1 Natural 1 Yes 2 V No Pendina Director: hours after ceath. 2 🗸 Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be Suicide or Town, State) 7500 block Greenbelt Road, Greenbelt, MD (Specify) Local Street determined Homicide 29a. Certifier 1 (Check only one) 2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b Signature and title of certifier March 7, 2010 OCME 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Ling Li, MD Assistant Medical Examiner 31. Date filed (Month, ar's Signat Registrar

ORIGINAL

only one) 29b. Signature

Director

Funeral

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Completed

Be

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Examine

Be Completed by Physician/Medical

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Certificate:

Medical

Physician/

Medical

Examiner

**Funeral** 

**Director** 

or 28a-f show

State Registrar			Cei	rtificate	e of E	eath			Reg. No.	2011	0 060	33.
Decedent's Name (First, Middle	, Last)			<u> </u>				2. Date of Dea	ith	- 0 1	3. Time o	<del>ل تر</del> f Death
Lillian		Edith		Hube	er			Month March	Day 4	Yea 2010	ar	
Facility Name (if not institution	give street and nun			1		Location	of Death	01-011		County of D		
Genesis	Healthcar			,		erna		ς		,	Arundel	
Social Security Number	6. Sex	7. Age (In yrs. la	ast birthday)	If Under	1 Year	If Under	24 Hrs.	8. Date of Birt		9.	Birthplace (State of	or Foreig
47-20-9167	1 □ M 2 🖾 F	89	Yrs.	Months	Days	Hours	Min.	(Month, Day August		1920	Country) New York	
ual Residence of Decedent												
. State 10b. County		10c. City	y, Town or Lo	cation							10d. Inside C	ity Limits
aryland Anne	Arundel	Mil	lersvi	lle							1 🗆 Yes	2 🖳 N
Street and Number				10f. Zip	Code				10g. Citiz	zen of What	Country?	
320 Sourwoo	d Ct.				211	.08			USF	A		
Marital Status		edent Ever in U.S			lent of Hi	spanic Ori		cify Yes or No-		4. Race - A	merican Indian,	
Never Married 2  Mar		2 😾 No		If Yes, spec	_			rican, etc.)		Black, W	/hite, etc.	
3 ⅓Widowed 4 ☐ Divorced	If Yes, Giv Year or Da			1 🗌 Yes	2 <u>k</u> M0	Specify:			8	Specify:	white	
	nt's Education			dent's Usua					16b. Kir	nd of Busine	ess Industry	
(Specify only highe Elementary/Seconday (0-12)	st grade completed) College (1			kind of wor O NOT use		uring mos	t of workii	ng			•	
12	College (1	7 OI JT)		Retai	.1				Re	etail	Sales	
Father's Name (First, Middle, I	ast)					18. Moth	er's Name	(First, Middle,				
John	J	Vaughn					lliar	·		Gan	es	
. Informant's Name/Relations	nip (Type, Print)		10b Meili	na Addross	/Street ~			l Route Number	City or 1			
			1	-								
Richard Walsh Method of Disposition		001 0				Koad		any Bea				
1 A Burial 2 Cremation	3 Removal from	State C	lace of Dispo emetery, crei	matory or o	ther place			Date			or Town, State	
4 Donation 5 Other (S		G	olf Pi	nes C	emet	ery	Marc	h 9 20	0 Ve	enice	Fla.	
Signature of Funeral Service	)cerree		22	2. Name an	d Addres	s of Facilit	y Sta	llings	Fune	ral H	ome P.A.	
hud.	XX 1/			311	1 Mo	unta		ad Pasa				
a. Part 1. Enter the disease, or	complications that	caused the death	n. Do not ent								Approxima	
shock, or heart failure. List omediate Cause (Final			m		A \$			1 \	~1	_	Interval Bet Onset and	ween Death
ease or condition sulting in death)		Or as a consequ		TE CARDIOVASEULAR DISEASE					456		YEAR	7
,	Due to	or as a consequ	ence ot):									
equentially list conditions,	b. —	/·										
any, leading to immediate use. Enter Underlying	Due to	or as a consequ	ience ot):									
use (Disease or iinjury at initiated events	с	,										
sulting in death) Last	Due to	(or as a consequ	ience of):									
	<b>d</b>											
CAAALE.	23c. If yes, out	come of pregna		7 make 1:					2	3d. Date of	delivery	
FEMALE: D. Was decedent pregnant		Birth 2  Feta		□ Ectopic p     □ Other (sp		у				Month	Day	Year
. Was decedent pregnant in the past 12 months?	4 Preg											
. Was decedent pregnant		10WII					l.	23e. Did to	bacco us	e contribute	e to the cause of o	leath?
. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	4 🗌 Preg 9 🗍 Unkr		ulting in the u	underlying o	cause giv	en in Part			/es 2	₩o 3 □	Probably 4 🗆	Unknow
. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	4 🗌 Preg 9 🗍 Unkr		ulting in the u	underlying o	cause giv	en in Part		1 🗆 '				
. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	4 🗌 Preg 9 🗍 Unkr		ulting in the u	underlying o	cause giv	en in Part						-
. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	4 🗌 Preg 9 🗍 Unkr		ulting in the u	underlying o	cause giv	en in Part		24a. Was a	an esy	prior	autopsy findings to completion of c	
. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	4 🗌 Preg 9 🗍 Unkr		ulting in the u	underlying o	cause giv	en in Part		24a. Was a autop perfo	an sy med?	prior death	to completion of on?	
. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  t II. Other significant condition	4 🗌 Preg 9 🗍 Unkr		ulting in the u	underlying o		en in Part	th (Check	24a. Was a autop perfo	an sy med?	prior death	to completion of o	
. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9  9 Unknown  t II. Other significant condition	4 ☐ Preg 9 ☐ Unkr	leath but not resi			26. Pla	ace of Dea		24a. Was a autop perfo 1 Yes	an sy med? 2 No	prior death 1 🔲	to completion of c 1? Yes 2  No	
Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown  t II. Other significant condition  Was case referred to medical examiner?  1 Yes 2 No	4 □ Preg 9 □ Unkr  ons contributing to d  Hospital: 1 □ 28a. Date	lnpatient 2 of injury	ER/Outpatiel	nt 3 □ DO	26. Pla	ace of Dea	ursing Ho	24a. Was a autop perfo 1 Ves only one)	an sy med? 2 No	prior death 1 🔲	to completion of c 1? Yes 2  No	
Was case referred to medical examiner?  I a yes 2 No  Was case referred to medical examiner?  Manner of Death  Manuer of Death  Manuer of Death	4 ☐ Preg 9 ☐ Unkr ons contributing to d Hospital: 1 ☐ 28a. Date (Mon	eath but not resi	ER/Outpatiel	nt 3 □ DC f 2:	26. Pla Othe	ace of Dea	ursing Ho	24a. Was a autop perfo 1 Yes	an sy med? 2 No	prior death 1 🔲	to completion of c 1? Yes 2  No	
Was case referred to medical examiner?    Was case referred to medical examiner?   Was case to medical examiner?	4 Preg 9 Unkr	lnpatient 2 of injury	ER/Outpatie 28b. Time o injury	nt 3 □ DC f 2:	26. Pla Othe DA 8c. Injury work 1	ace of Dea	No 2	24a. Was a autor perfo 1 Yes only one)  me 5 Resices Resident Resi	ence 6	prior death 1  Other (Sp. occurred	to completion of c 1? Yes 2  No	eause of

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. attending physician and for use as the burial-transit within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached

> State Registrar

31. Date filed (Month, Day, Year) MAR 09 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) おんけん C・WKLLACE, MI) 9005 32. Registrar's Signature

Covillanus

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

D31136 MARCH 7, 2010 KILBRIDE RD, BAUTIMORE, MD 21236

10-017 Carl Fr	and
	Fu Dir
136	thin 72 hours after death with the Maryland

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arl Francis Hu		s, Sr. State of Maryland / Department of Certificate of Certificat		nd Mental H	ygiene		
Physicia		Registrar  1. Decedent's Name (First, Middle,Last)	Death		2. Date of D	Reg. No.	3. Time of Death
ledical Exami					Month March 1	Day Year , 2010	1445 hrs
		4a. Facility Name (if not institution, give street and number)	4b. City, Town, c	or Location of Death		4c. County of Dea	ath
		2602 Northshire Drive	Baltimore		_	N/A	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Ye		8. Date of		Birthplace (State or Foreigr Country)
Director		250-54-2743   1∑M 2□F   75 Yr	Months Da	iys Hours Min.	Jan		uth Carolina
		Usual Residence of Decedent					10d. Inside City Limits
w any		10a. State 10b. County 10c. City, Town or Loca					1 X Yes 2 No
Maryland 28a-f show	tor	Maryland N/A Baltin	nore 10f. Zip Code		-	10g. Citizen of What Co	21
e Mar or 28s	Director	,, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		230		, and the second	,
death with the Maryland or items 23a or 28a-f sho	a D	2602 Northshire Drive 11. Marital Status 12. Was Decedent Ever in U.S. 13. W		∠SU lispanic Origin? ( Sp	ecify Yes or I	USA No- 14 Race - Am	erican Indian, Black,
eath w items	Funeral	1 Never Married 2 Married Armed Forces?		an, Mexican, Puerto		White, etc.	
fter de l", or	y FL	$ \begin{array}{c ccccccccccccccccccccccccccccccccccc$	Yes 2X N	o specify:		Specify: Wh	ite
ours a atura camir	d by			ation (Give kind of w		16b. Kind of Busines	
6 72 h cal E	lete	Elementary/Secondary (0-12) College (1-4 or 5+)	nost of working in	e. DO NOT use retir	ea)		
5-0036 led within 72 hours after Hygiene. I other than "natural" the Medical Examine.	Completed		orer		/F:	Construc	tion
filed Hyg		17. Father's Name (First, Middle, Last)		Lelia	`	e, Maiden Surname)	
Baltimore, MD 21215-0036  Speriit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of He land Mental Hygiene. Important: If item 77 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	To Be	Roger Huggins  19a. Informant's Name/Relationship (Type, Print)  19b. Mailir	ng Address (Stre			USOII lumber, City or Town, Sta	ite, Zip Code)
ore, MD 2 es 1 and 2 shou of Health and N If item 27 is n her traumatic		Wendell R. Huggins, Brother 2823	Old Jop	pa Road Jo	oppa,	Maryland 21	085
e, h l and Healtl item		20a. Method of Disposition 20b. Place of Dispo	sition (Name of co		Date	20c. Location - City	
nor ages at of other		The individual of the individu	* *	Inc   03	/04/10	Baltimor	e, Maryland
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite		4 Donation 5 Other Specify: Metro Cree 21. Signature of Funeral Service Lice Se	Name and Addre	ss of Facility	26 M	1 1 T	c, varyrana_
Balt permit. Depart Impor injury		21. Signature of Funeral Service Lice See Thomas Gregor Cr	:emation 99 Frede:	society ( rick Road	Jī Mar Balti	yland, Inc. more, Maryl	and 21228
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter failure. List only one cause on each line.	the mode of dying	g, such as cardiac or	respiratory a	arrest, shock, or heart	Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final disease a. Atherosclerotic Cardiovascular Dis	sease				Death
		or condition resulting in death)  Due to (or as a consequence of):					
	ē	Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):					
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated					
ecuted and and transit	Ä	events resulting in death) Last Due to (or as a consequence of):  d.					
Records, P.O. Box 68760,  The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - transi	Sa	UNPENDED AMENDED					
760, icate be exe	Physician/Medica	IF FEMALE: 23c. If yes, outcome of pregnancy				23d. Date of delive	ery
68760, certificate be nding physic	an/	past 12 months?	etal death 3	Ectopic pregna	ncy	Month	Day Year
Box 6  e death cer the attendi	sici	1 Yes 2 No 9 Unknown Pregnant at time of death 5 C	other (Specify)				
D. B t the d by the	된	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause	given in Part I.	23e. Did	I tobacco use contribute t	to the cause of death?
, P.O ires that to signed botto	ğ	Chronic Alcoholism			1 🗌 Y	res 2 No 3 Pr	obably 4 🗸 Unknown
rds, requir been s	Completed				24a. Wa		autopsy findings available completion of cause of
Recol The law cate has	du				per	formed? death?	
		25. Was case referred to medical	26.Plan	ce of Death (Check of		3 2 10	2 100
of Vital Records, ng Physician: The law require of this certificate has been so meral director, page 2 should the	To Be	examiner?  1 ✓ Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatien	nt 3 DOA	Other Nursin	g Home 5	Residence 6 🗸 Oth	er: Scene
n of ing Ph	i.	27. Manner of Death 28a. Date of Injury 28b. Time of	· · · · ·	ury at Work?	28d. Describ	e how injury occurred	
ion rtendi leath. tor:	ațio	1 V Natural 5 Pending 2 Accident Investigation	1	Yes 2 No			
Division tal or Attendir s after death. al Director: A	Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, stre	et, factory, office	building, etc.	28f. Location or Town	(Street and Number or F , State)	Rural Route Number, City
Di spital hours a neral I		4 Homicide determined (Specify)  29a. Certifier A Department of the host of my knowledge death age.					
Division of Vital   To the Hospital or Attending Physician: within 24 hours after datted. After this certif To the Funeral Director: After this certif completely filled in by the funeral director.	Medical	Check only  1 Certifying Physician: To the best of my knowledge, death occurrence on the basis of examination and/or investigation.					
To T	Med	and manner stated.  29b' Signature and title of certifier	29c. Licer	nse number		29d. Date signed (M	lonth, Day, Year)
		(Ca Culo MA)	O.C	c.M.E.		March 2, 2010	
1.1.1		30. Name and address of person who completed cause of death (Item 23a)					
41,		Laron Locke MD. Assistant Medical Examiner 111 Pen	n Street, Balt	imore, MD 2120	01		
		31. Date filed (Month, Day, Year) 32. Registrar's Signature	1.00				
Regis	ıralı	MAR 09 2010 Come B. A	rangel				

DHMH 17 Rev 1/2001 OCME 2006

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ORIGINAL

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Robert C Harrison	State of Ma 1- For State Registrar	ryland / Department o Certificate of		- '	g. No. 201	0 06939
Physician/ Medical Examine		RISON, JR.		2. Date of Death Month March 7, 2	Day Year	3. Time of Death 1525 hrs
<	4a. Facility Name (if not institution, give street an Johns Hopkins Bayview Medical (		4b. City, Town, or Location of Deat Baltimore		4c. County of Death	<u> </u>
Funeral Director	5. Social Security Number <b>UNK</b> 6. Sex 217–44–3594 1 M 2	7. Age (In yrs. last birthday)  F 65 Yrs	If Under 1 Year If Under 24Hi Months Days Hours Mi		Co	thplace (State or Foreign untry) MD
any	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Locat	ion			10d. Inside City Limits
f show once	MD	BALTI				1 X Yes 2 No
th the Maryland 23a or 28a-f sho notified at once	10e. Street and Number  1609 ELRINO ST.		10f. Zip Code 21224	10	g. Citizen of What Cou <b>USA</b>	ntry'?
5-0036 led within 72 hours after death with the Maryland stygiene. other than "natural", or items 23a or 28a-f she the Markel Examiner must be notified at once Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married Arm	ed Forces? If Y	s Decedent of Hispanic Origin? ( Ses, specify Cuban, Mexican, Puert		White, etc.	ican Indian, Black,
urs afte	or Dates:	t grade completed) 16a. Deceder	Yes 2 No specify: t's Usual Occupation (Give kind of		Specify: I 16b. Kind of Business/	BLACK Industry
21215-0036 uld be filed within 72 hour Mental Hygiene. marked other than "natu c event, the Mentel Exau To Be Completed	Elementary/Secondary (0-12) Colle	ge (1-4 or 5+)  MUSIO			ENTERTAIN	1ENT
_ E - D - I - O	17. Father's Name (First, Middle, Last)  ROBERT C. HARRISON,	SR		ne (First, Middle, M N ROBINS		
and sh	19a. Informant's Name/Relationship (Type, Print CHARLOTTE DEMPSEY/FIA		Address (Street and Number or 9 ELRINO ST., B.			e, Zip Code)
or Land	20a. Method of Disposition  1 Burial 2 Cremation 3 Remove  4 Donation 5 Other Specify:	val from State crematory or ot		Date <b>9/10</b>	BALTO., MI	
Baltimo permit. Page Department of Important: injury or oth	21 Signature of Funeral Service Licensee	22. N	lame and Address of Facility JA			
Physician // Medical	23a/Part I. Enter the disease, or complications the failure. List only one cause on each line.	hat caused the death. Do not enter t	ne mode of dying, such as cardiac	or respiratory arre	st, shock, or heart	Approximate Interval Between Onset and
aminer		clerotic Cardiovascular Dis as a consequence of):	ease			Death
	Sequentially list conditions, if any, leading to immediate Due to (or	as a consequence of):				
ted Insit Examiner	(Disease or injury that initiated C.	as a consequence of):				
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50, te be executed ysician and burial - transit		ED 5 per fh g901	3-11-10 vt			
OX 6876 eath certificat e attending phy for use as the	past 12 months?	Pregnant at time of death	tal death 3 Ectopic pregr ner (Specify)	nancy	23d. Date of deliver Month	y Day Year
P.O. B es that the d igned by the detached	Part II. Other significant conditions contributi	ing to death but not resulting in the u	inderlying cause given in Part I.		pacco use contribute to	
duires then signed and be defined by	ļ <del></del>			1 Yes	2 No 3 Prol	utopsy findings available
of Vital Records, P.C og Physician: The law requires than ther this certificate has been signed meral director, page 2 should be det n: To Be Completed by			20 81 (2) 11 .0	autops perforr 1 Yes 2	sy prior to o	completion of cause of
Vital ysician ysician directo	25. Was case referred to medical examiner?  1 VYes 2 No	Inpatient 2 FR/Outpatient	26 Place of Death (Check 3 DOA Other Nurs	ing Home 5 F	Residence 6 Othe	r:
ision of Vital Rec Attending Physician: The ordeath. rector: After this certificate by the funeral director, page feation: To Be Con	27. Manner of Death 1 Natural 5 Pending	Date of Injury 28b. Time of I Month, Day, Year)	njury 28c. Injury at Work?	28d. Describe he	ow injury occurred	
Division o spital or Attending tours after death. neral Director: After filled in by the fure Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined (Spe	Place of Injury - At home, farm, stree	et, factory, office building, etc.	28f. Location (St or Town, Sta		ıral Route Number, City
To the Hosy within 24 hr To the Fun completely Medical (	one) 2 Medical Examiner: On the ba	e best of my knowledge, death occur asis of examination and/or investigat ner stated.				
	29b. Signature and title of certifier	alan	29c License number O.C.M.E.		29d. Date signed (Mo	nth, Day, Year)
	30. Name and address of person who completed Carol Allan, MD Assistant Medi		Street, Baltimore, MD 212			
State	31. Date filed wonth On North 3.	2 Registrar's Signature	A SURVINION NAME OF THE PARTY O		-	
Registra	The state of the s	wi B. Jak	<i>5</i> ′			

DHMH 17 Rev 1/2001 OCME 2006 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			for State	State of Ma	aryland /	-	ent of Healt ate of Deatl		Mental Hy	giene	210	00010
		i	Registrar  1. Decedent's Name (First, Middle, La	st)		Cerund	ale of Deali	<u> </u>	2. Date of De	Reg. No.		3. Time of Death
	Physicia Medic		Richard		Но	opert			March March		0 Year	11:00 AM
	Examin		4a. Facility Name (if not institution, give			4b. (	City, Town, or Location			4c. Cour	nty of Death	
mayed	Funeral		7709 Old Battle G		(In yrs. last bir	thday) If U	Dundalk	der 24 Hrs.	8. Date of Bir		ltimo:	re place (State or Foreign
	Director		213-64-8565	X M 2 □ F	56	Yrs. Mon			(Month, Da Februa:	v. Year)	954 Cour	ntry)  Mary Land
	nd how at	ř	Usual Residence of Decedent  10a. State 10b. County		10c. City, Tow	n or Location						10d. Inside City Limits
	Aaryla 8a-f s tified	Director	Md. Ba	ltimore			Dundalk					1 🗆 Yes 2 🔀 No
	a or 2 be no	al Di	10e. Street and Number			10f	. Zip Code		I	10g. Citizen o	f What Cour	ntry?
	ath with	Funeral	7709 Old Batt	le Grove Ro		140.11/ 5	212				USA	
36	filed within 72 hours after death with the Maryland tal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	þ	Never Married 2 ★ Married     Widowed 4 □ Divorced	Armed Forces? 1 ☐ Yes 2 🔀N If Yes, Give		If Yes,	ecedent of Hispanic of Specify Cuban, Mexicons 2 🔀 No Spec	can, Puerto	ecify Yes or No- Rican, etc.)		ace - Americ lack, White, fy: Wh:	etc.
9	hours natura dical E	Completed	15. Decedent's E	Year or Dates.	16a		Jsual Occupation			16b. Kind of		
21	hin 72 ne. <b>than "</b>	dwo	(Specify only highest gr Elementary/Seconday (0-12)	College (1-4 or 5+	-)	life. DO NOT	,		ing			
d 2	ed wit Hygie other:	Be C	12 Years 17. Father's Name (First, Middle, Last)			Chemi	cal Operat		e (First, Middle,		hemica	<b>∃</b> T
/lan	ould be filed d Mental Hy marked oth matic event	ပ္	Russell Clyde	Hoopert			16. 1910	Ire	, ,	nor Ble	,	
Baltimore, Maryland 21215-0036	short and range.	1	19a. Informant's Name/Relationship (1 Sherry Hoopert	ype, Print) Wife	198	. Mailing Add	ress (Street and Nun ld Battle	nber or Rura <b>Grove</b>	Route Numbe	r, City or Town, Dunda l	State, Zip (	Code) 21222
ore,	of Hea of Hea f item		20a. Method of Disposition			f Disposition (	Name of	_	Date 9,	20c. Location		
<u>H</u>	Page tment tant: I	H	1 ☐ Burial 2 X Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci			ew Cre	natory	Marc 201		Baltim	ore, N	Maryland
Baj	permit. Page 1 and 2 Department of Health Important: If item 2' any injury or other t		21. Signature of Fundal Service Licen:	Conne	ller	/ Con	and Address of Fac nelly Func O Sollers	eral I	Home Of	Dundal	k, P. <i>I</i>	A. 21222
			23a. Part 1. Enter the disease or comshock, or heart failure. Ust only company to the company of	plications that caused t ne cause on each line.	he death Do i	not enter the r	node of dying, such	as cardiac o	or respiratory are	rest,	<del>~ /                                     </del>	Approximate Interval Between
7	Pnysician, Medical	4	Immediate Cause (Final disease or condition resulting in death)	e or condition								
	Examiner	П		attially list conditions,								
	n #	iner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying	b. Our to (or as a	nonsequence	Jy						
	and and I-trans	Examiner	Cause (Disease or iinjury that initiated events resulting in death) Last	c. Due to (or as a	consequence	of):					$-\bot$	
0	certificate be executed nding physician and use as the burial-transi	edical		l d		,-						
68760	tificate ng phy as the		IF FEMALE:									
Box 6	tth cert ttendir or use	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of	☐ Fetal deat						ate of delive	
B	requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Physician/N	1  Yes 2 No 9 Unknown	4 ∐ Pregnant at t 9 ☐ Unknown	ime of death	5 Other	(specify)			IV	Ionth	Day Year
О	s that t gned b	ջ	Part II. Other significant conditions of	ontributing to death but	not resulting i	n the underlyi	ng cause given in Pa	art I.	23e. Did to	bacco use cor	tribute to th	e cause of death?
rds,	equire	sted					_		1 🗆 🗅	∕es 2 □ No	3 🗆 Prob	pably 4 Unknown
or Vital Records,	has b	Completed							24a. Was a autop	sy	Were autop prior to cor death?	osy findings available npletion of cause of
Ť	an: The tificate tor, pay	Ф	25. Was case referred to fiedical				26. Place of De	eath (Chaol	1 🗆 Yes	rmed? 2 No	1 Yes	2 🗆 No
Ĭ	hysici; nis cer I direc:	10 B	examiner? 1  Yes 2 No	Hospital: 1	t 2 ER/Ou	tpatient 3	Othori		me 5 Resid	ence 6 🗆 Otl	ner (Specify)	
0 u	ding P h. After ti funera	ate:	27. Man → of Death 1 Natural 5 □ Pending	28a. Date of injury (Month, Day,	28b. 7 Year) i	ime of njury	28c. Injury at work?	2	28d. Describe h			
DIVISION	Attencr death	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined		- At home, fa	rm, street, fac	1 \sum Yes 2		28f. Location (S	treet and Numi	har or Puml	Pouto Number
<u>≥</u>	tal or, rs afte al Dire		4 - Homicide determined	building, etc. (		, , , , , ,	,,		City or Tow		Der Of Hurai	noute Namber,
	Hospi 24 hou Funer eted fill	Medical	(Check 2 in predical exacti	sician: To the best of m ner: On the basis of exa	mination and/o	r investigation.	in my opinion death	occurred at	the time date ar	ad place and di	in to the only	co(a) and manner stated
Section   Sect									nanner as sta	ited.		
			· AK				H005	1173		2)8	110	,
		ļ	30. Name and address of person who can buse to be a supported by the support of t	ompleted cause of dea	th (Item 23a) (	Type, Print)	\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	1500	*314	BALT	)Morr	5, MV 2123
	State	_		32. Registrar's			ا مربع والم		17 277			7 . 7 4 (4)
	Registra	r	31. Date find ART 09 2010	perma 1	J. Apa	1						

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2010 CICHARD /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4703 Bayfield Road Anne Arundel Harwood 9. Birthplace (State or Foreign Country) Washington DC If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, You Sept 14, 6. Sex 7. Age (In yrs. last birthday, **Funeral** Months Days Year. 12 M 2□ F Min Director 220-28-6851 76 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show event, the Medical Exactions must be notified at Director 1 ☐Yes 2☐No Anne Arundel MD Harwood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4703 Bayfield Road 20776 "natural", or items 23a USA Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1X Yes 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 55-57 1 ☐ Yes 2 📉 No Specify. Specify: White ð 3 Widowed 4 Divorced Completed unk 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the Mental Injury or other traumatic event injury or other e 12 1ithographer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be May Richter William WAgner Heintz ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4703 Bayfield Road Harwood, MD Shirley Heintz/spouse 20776 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) Signature Funeral Source Ronal S State Anatomy Board 655 W. Baltimore Street rector Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** RONAR MSEASE Dan /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Hospital or Attending Physician; The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) signed by the a ☐Yes 2 ☐No □Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ BAAIN 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed HAUNG Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? 1 □ Yes 2 □ No certificate 2 No director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 \sum Nursing Home 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of After 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 □Yes 2 □ No investigation the 24 hours after deat Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2. To the I

State Registrar

MAR 09

29b. Signature and title of cortifier

31. Date filed (Month, Day, Year)

Name and address of person who completed cause of death (Item 23a) (Type, Print) 441 Registrar's Signature

FENSE

29c. License number

29d. Date signed (Month, Day, Year)

**Funeral** Director

	1 - For State Registrar	Olalo of IVI		Certificate of		Reg. N	ZUIU	05942		
cian	1. Decedent's Name (First, Middle John Edward Han					2. Date of Death Month February	26 2010	3. Time of Death		
ical	4a. Facility Name (If not institution			4h City Town of	r Location of Death		c. County of Death	12:00 P M		
ner	2624 Jolly Acre			White			Harford			
		6. Sex 7. Ag	ge (In yrs. last birthd		If Under 24 Hrs. Hours Min.	8. Date of Birth	9 Rinth	place (State or Foreign		
	212-28-5547	1 M 2 □ F	83 Yrs	S. Months Days	Hours Will.	Noc 23, 1	926 Mai	yland		
	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits		
ţ	MD Har	ford	White	e Hall		1 □Yes 2√∏ No				
Director	10e. Street and Number	1014		10f. Zip Code		10g. (	Citizen of What Cou	intry?		
	2624 Jolly Ac	res Road			21161		USA			
Funeral	11. Marital Status	12. Was Decedent Armed Forces?		<ol> <li>Was Decedent of H If Yes, specify Cuba</li> </ol>	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White,			
by F	1 ☐ Never Married 2 Marri 3 ☐ Widowed 4 ☐ Divorced	ed 1 ☐ Yes 2 ☒ If Yes, Give Year or Dates:	No	1 ☐ Yes 2 <b>X</b> No	Specify:		Specify: W	nite		
ted	15. Decedent	's Education		ecedent's Usual Occup		16b.	Kind of Business/Ir	ndustry unit		
Completed	(Specify only highes Elementary/Secondary (0-12)	College (1-4or 5	Iii	ive kind of work done of e. DO NOT use retired	during most of work d)	ing				
	11	0	С	arpenter		(F)				
Be	17. Father's Name (First, Middle, L Charles Will					e (First, Middle, Maide t Elizbeth	•			
ဥ	19a. Informant's Name/Relationsh		19h M	ailing Address (Street				in Code)		
	Lucille S. Har			24 Jolly A				1161		
	20a. Method of Disposition	- 5-	20b. Place of Di	sposition (Name of crematory or other place		Date 20c.	Location - City or T	own, State		
	1 ☐ Burial 2 ☐ Cremation 4 ☑ Donation 5 ☐ Other Sp				1					
	21. Signature of Funeral Service L ROTIS C	icensee Wade, Dir	ector	22 Name and Addre	ss of Facility Comy Boar	d 655 W. E	Baltimore	Street		
	1mny	1////		Baltimore	, MD 212			A		
	a. Part 1. Enter the disea e. / r o shock, r heart failure. List o Immediate Cabse (Final	only one cause on each li			ig, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death		
	disease or condition resulting in death)	a. Car		rest						
	Due to (or as a consequence of):									
ner	b. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that injulated events c.									
Examiner	Cause (Disease or injury that initiated events c									
Medical	d									
	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		_		23d. Date of delivery				
Physician/I	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 ☐ Pregnant a		3 ☐ Ectopic pregnanc 5 ☐ Other (specify) _	у	23d. Date of delivery  Month Day Year				
hys	9 ☐ Unknown	9 ∐ Unknown								
ρ	Part II. Other significant condition	ns contributing to death b	out not resulting in th	e underlying cause give	en in Part I.			the cause of death?		
sted	assis	margeer	ever			1 Tes	2∐No 3⊌Pro	bably 4 Unknown		
Completed	Coope	ugeal D	trelul			24a. Was an autopsy	prior to c	opsy findings available ompletion of cause of		
	Rene	& Failur	e			performed 1 □ Yes 2 ☑1	death? No 1 ☐ Yes	2 🗆 No		
Be C	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	ОП <u>ГВ/О</u>	tiont 2 Dog Othe	er: _	h (Check only one)				
J: To	27. Manner of Death	28a. Date of Inju	ent 2 ER/Outpa	e of 28c. Injur	y at	28d. Describe how in	6 ☐ Other (Speciary occurred	ify)		
atio	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investiga		ry, Ye <i>ar)</i> Inju	ry Work	Yes 2 □ No		,,			
Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ned   28e. Place of Inj	ury - At home, farm, c. (Specify)	street, factory, office		28f. Location (Street City or Town, Sta	and Number or Rui	ral Route Number,		
	,						,			
Medical	29a. Certifier 1	g Physician: To the best Examiner: On the basis of and manner st	of examination and/c	eath occurred at the tir or investigation, in my o	me, date and place, pinion, death occur	and due to the cause red at the time, date a	e(s) and manner as and place, and due	stated. to the cause(s)		
ž	29b. Signature and title of certifier	Alexan Mr	)	29c. Licens	11 5	29d. [	Date signed (Month	, Day, Year)		
	yame		<i>,</i>	Door	5044		3/1/10			
	30. Name and address of person v	who completed cause of d	leath (Item 23a) (Typ	pe, Print) Webblav	ic Fawn	GOURTA	17321			
ite	31. Date filed (Month, Day, Year)	32. Registr	rar's Signature	booker						
rar	MAR 09	2010 Comm	~ p. /		-					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ 241 William T. Hale Jr Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death 4b. City, Town, or Location of Death Greneral timore Social Security Number 7. Age (In vrs. last birthdav. 1 Year If Under 24 Hrs. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🛛 M 2 🗆 F Months Hours Min Dec 13 Days Year 932 Director 220-48-8695 77 Maryland Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho amportant: If item 27 is marked other than "natural", or items 23a or 28a-f sho ampinuty or other traumatic event, the Medical Examiner must be notitified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Baltimore 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 700 W. 40th Street 21211 USA . Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🎇 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. Completed by 1 X Never Married 2 Married Báltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 🕅 No Specify: white Specify 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 16b. Kind of Business Industry (Specify only highest grade completed) life. DO NOT use retired Elementary/Seconday (0-12) College (1-4 or 5+) disabled none Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ William Taylor Hale Sr Vera G. Rock 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1627 Worthington Heights Cockeysville, MD 21030 Brian Hal/nephew 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) . Signature Kon 11d ²² Name and Address of Facility Board 655 W. Baltimore Street MD 21201 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line Interval Between Immediate Gause (Final Adeno Onset and Death Physician/ carcinoma disease or condition resulting in death) Medical Ascites S/p Chest Tube Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine signed by the attending physician and debetached for use as the burial-transi law requires that the death certificate be executed that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death Other (specify) Month Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗗 Unknown completed filled in by the funeral director, page 2 should After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The I within 24 hours after death.

To the Funeral Director: After this certificate h performed Yes 2 2 No Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred Natural injury 5 Pending Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifie 89631

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RAHULKUMAR

31. Date filed (Month, Day, Year,

GULAB

m.D. 40 Maryland Gueneral Hospital

0-01829		Please Type or Put in Black Indelible Ink. Ensure All Copi Are Legible.	011
akeisha Harris		State of Maryland / Department of Health and Mental Hygiene  1. For State  Certificate of Death  Reg. No.	0946
Physici	an/	1. Decedent's Name (First, Middle,Last)  2. Date of Death Month Day Year	
Medical Exami	ner	Lakelsha Trole Harrison March 4, 2010 1645. City, Town, or Location of Death 4c. County of Death	IIIS
		3502 Woodbrook Avenue Baltimore	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 M 2 F / 9 Yrs.  1 M 2 F / 9 Yrs.  1 M 2 F / 9 Yrs.  1 Months Days Hours Min.  1 Min.	ate or ry lang
ow any		AAN O //	de City Limits
t with the Maryland ms 23a or 28a-f show be notified at once.	Director	10e. Street and Number  10f. Zip Code  10g. Citizen of What Country?	
ath with the items 23a o	Funeral D	10 100 11011100 1101100 1 21211	, Black,
2 hours after de "natural", or i Examiner mu	þ	3 Widowed 4 Divorced in res, one rear or Divorced in rear or Divo	<u>K</u>
36 in 7; han tical	ompleted	Elementary/Secondary (0-12) College (1-4 or 5+)	arylan
21215-0036 build be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be C	Troy 5 Harrison Lyn Z. Hermson	)
→ 오늘 말 글	L L	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code  LUN Z. Harrison (Mother) 3403 Holmes Ave. Baltimore, MD.	) 2/2/ <b>7</b>
traffea a		20a. Method of Disposition	te
Baltimore, permit. Pages 1 a Department of He Important: If ite injury or other to		1 Burial 2 A Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify: Crematory 3-6-2010 Balthmore,	MD
Salti ermit. Departm mports njury o		21_Signature of Funeral Service Licensee (22_Name and Address of Facility reene Funeral Service Valuation)	ces,
Physician			mate Interval
/Medical Examiner			n Onset and Death
LAMITHIE		or condition resulting in death)  Due to (or as a consequence of):	
	ner	Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):	
0	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):	
760, icate be executed sphysician and the burial - transit	_	Q.	
o, e be ex ysician burial	ledic	UNPENDED AMENDED  IF FFMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery	
Box 68760, e death certificate but the attending physical for use as the but	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify)	Year
Box e death the atte	hysic	1 Yes 2 No 9 V Unknown 9 Unknown	
ords, P.O.  v requires that the s been signed by t	ð	1 Yes 2 No 3 Probably 4	_
ords, w requires is been sig	Completed	24a. Was an 24b. Were autopsy findi	
Recor The law 1 icate has b page 2 sh	du	autopsy prior to completion performed? death?  1  Yes 2 ✓ No 1 Yes 2	of cause of
Vital Reco hysician: The law this certificate has I director, page 2 s	ادہ	25. Was case referred to medical 26. Place of Death (Check only one)	
Vita hysici r this c	To B	1 Ves 2 No Inpatient 2 EK/Outpatient 3 DOA Nursing Home 5 Residence 6 Votner Scene	
on of ending Ph ath or: After the funeral		27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury Mar 4, 2010 28b. Time of Injury 0201 hrs 28c. Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred Victim of house fire	
Division of Vital Records, ital or Attending Physician: The law requir us after death ral Director: After this certificate has been silled in by the funeral director, page 2 should the control of the funeral director, page 2 should the funeral director, page 2 should the funeral director.	Certification:	2 V Accident Investigation 3 Suicide 6 Could not be determined Homicide Homicide Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 376 (Specify) Townhouse / Rowhouse 3502 Woodbrook Avenue, Baltimore, MD	Number, City
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burn	Medical C		
F 3 F 8	Me		ear)
2		O.C.M.E. March 4, 2010  30. Name and address of person who completed cause of death (Item 23a)	
<i>U</i> ~		Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
S	tate	31. Date filed (Month, Day Year) 32. Registrar's fignature	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 20 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Jenkins Month Year **Physician** Anthony Michael March 2010 1:15 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner The Johns Hopkins Hospital **Baltimore City** | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Days Hours Min. (Month, Day, Year May 3, 1 5. Social Security Number 9. Birthplace (State or Foreign Country)
New York 7. Age (In yrs. last birthday) **Funeral** 1 🗙 M 2 🗆 F Director 134-46-9255 53 1956 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hygiene. Important: If titen 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Example. 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Director Maryland Baltimore County Baltimore 10e. Street and Numbe 10f, Zip-Code 10g. Citizen of What Country? 926 Regester Avenue 21239 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ▼ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married If Yes, Give þ 1 ☐ Yes 2 No Specify. Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 5+ Elementary/Secondary (0-12) Hospital Administrator Medical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Arnold Cortez Jenkins Catherine Ruth Rahming 0 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Virginia Grant (Pers. Rep.) 628 Lake Drive, Towson, Maryland 21286 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition

1 □ Burial 2 □ Cremation 3 □ Removal from State

4 □ Donation 5 □ Other (Specify)

21. Signat 1 1 Fun □ Berv (License e

Martin D Lawson Green Mount Crematory 3/8/2010 Baltimore, Maryland 22. Name and Address of Facility

Martin D. Lawson

23a. Part 1. Enter the disease, or complications that caused the death. Shock, or heart failure. List only one cause on each line.

25a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximation v. 37 07 2010

Baltimore, Mary

25a. Name and Address of Facility

MITCHELL-WIEDEFELD FUNERAL HOME, INC.

6500 York Road, Baltimore, Maryland

21212

Approximation v. 37 07 2010

Baltimore, Mary

Baltimore, Mary

Baltimore, Mary

Approximation v. 37 07 2010

Baltimore, Mary

Baltimore, Mary Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** BURKITT'S LYMPHOMA disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of) physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death Live birth 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) director, page 2 should be detached 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? \$ Completed 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy nours after death.

neral Director; After this certificate ha
| filled in by the funeral director, page performed? 2 No 2 🗌 No 1 🗌 Yes Hospital or Attending Physician; 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 - Nursing Home 1 ☐ Yes 2 ☑No 1 Sinpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ 6 Other (Specify) 5 Residence 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation Injury 2 Accident 1 Yes 2 🗌 No 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

State Registrar

Division of Vital Records, P.O. Box 68760,

31. Date filed (Month, Day, Year) MAR 09 2010

Lupa Kushnasmonic

RUPA KRISHNASWAMY 32. Registrar's Signati

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

march 5, 2010

600 North Wolfe St, Baltimore, MD, 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. MARCH 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 03 Day 14291 07 DM Medical 4a. Facility Name (if not institution, give street and number) MEDICAL **Examiner** 4b. City, Town, or Location of Death 4c. County of Death MOR Social Security Number **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Month, Day, 1 213-54-2547 1 □ M 2 🂢 F Months Days Hours Min Maryland **Director** 1949 June Usual Residence of Decedent show should be filed within 72 hours after death with the Maryland ms 23a or 28a-f sho must be notified at 10c. City, Town or Location Director 10d. Inside City Limits Maryland Baltimore Dundalk 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7039 East Baltimore Street 21224 USA "natural", or item ledical Examiner n 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 X Never Married 2 Married Completed by 1 Yes If Yes, Give Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) if. Page 1 and 2 should be med. .... artment of Health and Mental Hygiene. 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 years Classified years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Karmilovich Mary Lou Zeman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Degutis sister 12534 Urlich Avenue, Middle River, MD. 21220 permit. Page 1 and Department of Healt Important: If item 2 any injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State March 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place. Sacred Heart of Jesus Cem. 2010 Dundalk, Maryland 22. Name and Address of Facility Connelly Funeral H 7110 Sollers Point Signature of Funeral Service Licensee Home Of Dundalk,P.A. nt Road, Dundalk,Md. 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure, List only one cause on each line. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Ph sician/ Onset and Death STRUANGULATED disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death Other (specify) Month Day Year 1 ☐ Yes 2 I 9 Unknown ģ signed to d be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy After this certificate funeral director, pag performe Yes 2 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No Other: မ 1 Yes 1 Unpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending within 24 hours after death

To the Funeral Director: 

completed filled in by the f Accident Suicide 1 Yes 2 🗌 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 29c. License number 29d, Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 7/2009

address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MARCH KEELING 15-15 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death HOPKINS BAUTIMORE SMHOL BAYVIEW MEDICAL CENTER 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) 1 😾 M 2 🗆 F Months Hours (Month, Day, Director 410-54-6652 Tennessee Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importanti If item 27 is marked other than "natural", or items 23a or 28a-1 shown injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland Harford 1 Yes 2 No Darlington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 3407 Cedar Church Road 21034 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🛣 No Black, White, etc. 1 Never Married 2X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. 3 Widowed 4 Divorced Specify White Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Security Company Security Guard Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည <u> Albert William Keeling</u> <u>Mamie Beatrise Foster</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Georgia Keeling / Wife</u> 3407 Cedar Church Rd., Darlington, MD 21034 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 3-8-10 Darlington, Maryland Darlington Cemetery 22. Name and Address of Facility McComas Funeral Home 1317 Cokesbury Road, of Funeral Service Licenses Home, P.A. Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart railure. List only one cause on each line. Immediate Cause (Final NON SHALL CELL LUNG CANCER Pitysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner If tany, leading to in medicause. Enter Underlying Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and been signed by the attending physician and should be detached for use as the burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 3 Probably 4 Unknown Completed 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 2 No funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? ပ္ 1 Tes Other: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work' Accident 1 ☐ Yes 2 ☐ No Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number, cal 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) March 3rd, 2010 -UN MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WANSOM, MD 4940 BASTERN ANE, BALTIMORE, MD 31. Date filed (Mor State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ MARCH Medical 4a. Facility Name (if not institution, give street and number) County of Death Examiner 4h City Town or Location of Death a If Under If Under 24 Hrs. 9. Birthplace (State or Foreign Country) MARY LAND 8. Date of Birth **Funeral** 1 M 2 M F Months Q Day, **Director** Usual Residence of Decedent or 28a-f shov 10a. State within 72 hours after death with the Maryland er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 ☑ No 10f. Zip Code 10g. Citizen of What Country? 2123 Funeral INITED Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Eyer in U.S. 14. Race - American Indian, Armed Forces? 1 Never Married 2 Married 2 Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 1 No Specify 3 ₩ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life, DO NOT use retired) should be filed within 72 Is and Mental Hygiene. (Specify only highest grade completed) econday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event; Be 17. Father's Name (First, Middle, Last, မ Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other particles) 20a. Method of Disposition 20c. Location - City or Town, State 1 W Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Furieral Service Licensee 23a. Part 1. Entet the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ 10 hm disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of). burial attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) Month Dav Year Pregnant at time of death the 9 Unknown Unknown Records, P.O. been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an icate has t ; page 2 s autopsy performe certificate 2 🗌 No 1 🗌 Yes Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical examiner?
1 ☐ Yes 2 X No **Division of Vital** Be 26. Place of Death (Check only one, Hospital Other: ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 M Residence 6 ☐ Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural work 1 🗌 Yes 2 🗌 No Accident Investigation □ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of ce 30. Name and addies s of cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death A 2. Date of Death Februar Physician/ Bernard C. Kefauver Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death 4b. City, Town, or Location of Death Washington County Hospital Hagerstown Washington . Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth June 12, 1927 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Days 219-20-1693 Director 82 Maryland Usual Residence of Decedent 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 10c. City, Town or Location 10d. Inside City Limits er than "natural", or items 23a or 28a-f s the Medical Examiner must be notified 1 Tes 2 X No MD Washington Williamsport 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 114 N. Conococheague Street 21795 USA 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify. white 3 Widowed 4 Divorced 45-57 Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done life. DO NOT use retired) during most of working alth and Mental Hygiene.

27 is marked other than r traumatic event, the M. Elementary/Seconday (0-12) College (1-4 or 5+) 12 <u>technician</u> biological Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Earl Samson Kefauver Ethel Michael 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. Patricia Getridge/sister 3 Della Lane Boonesboro, MD 21713 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Signay re of Funeral Service Licensee Ronald S Wade 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201 Director . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final disease or Indition Onset and Death Physician/ Medical resulting in death) Due to (of as a consequence of): Examiner Sequentially list conditions, if any cause. Enter Underlying Cause (Disease or linjury Due to for as a nonsequence of Exami physician and s the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 attending phase as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year 2 No the 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas performed? Yes 2 No certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 X No Other: မ 1 🔲 Yes 1 Inpatient 2 I ER/Outpatient 3 I DOA Director: After this 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 🗱 Natural 5 Pending 2 Accident
3 Suicide Investigation 1 Yes 2 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours af To the Funeral Di completed filled in Medical 29a. Certifier Q Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANZAR 36 8 mull N ADI 31. Date filed (Month, Day, Year) 82. Registrar's Signature Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death MARCH Year 2010 16.34 A SHARY KABILJO 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death SEASONS HOSPICE RANDALLSTOWN BALTIMORE If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth Month, Day, Year 7/11/1918 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 □ M 2 1 F YUĞÜĞLAVIA 91 217-38-1348 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6624 SANZO ROAD, APT. 21209 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. Specify: WHITE 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) LIBRARY PAGE PUBLIC SERVICE College (1-4or 5+) BOOK BINDER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) MORITZ **MONTILJO FLORA** MUSAFIA 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LINDA COHEN/DAUGHTER 26440 IRVING ROAD, FRANKLIN, ΜI 48025 20b. Place of Disposition (Name of Cemerals Aremetors of alber place) CHESED CEMETERY 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 3/7/2010 RANDALLSTOWN, MD 21. Signature of Funeral Service License SOL LEVINSON & BROS., INC. ) Vin 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one gause on each line. 1) WEAS Immediate Cause (Final THEROSCL disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (5) as a consequence of Due to (or as a consequence of): IF FEMALE If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent premant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) ☐Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?

Physician /Medical **Examiner** 

Department of H Important: If ite any Injury or ot once.

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

ral", or Items 23a or 28a-f shov Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours after death vant of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or Items 23, ury or other traumatic event, it as Medical Experimental ury or other graumatic event, it as Medical Experimental.

Baltimore, Maryland 21215-0036

Director

Funeral

Completed by

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Examine signed by the attending physician and be detached for use as the burial-trar peen

has To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral

The law requires that the death certificate be executed

P.O. Box 68760,

Division of Vital Records,

Physician/Medical \$ Completed Be ၉ Certification: Medical

State Registrar

SEIZUK	U į	SISORDEI(				-	1 Yes 2 No 3 Probably 4 Unki	nown
							24a. Was an autopsy performed?  1 □ Yes 2 □ No 1 □ Yes 2 □ No	
25. Was case referred to m examiner?	edical				26.	. Place of Deat	h (Check only one)	
1 Yes 2 No	H	ospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3	DOA	Other: 4	4 ☐ Nursing Ho	ome 5 Residence 6 Other (Specify)	2
2 ☐ Accident in	Pending nvestigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c.	Injury at Work?		28d. Describe how injury occurred	
	Could not be letermined	28e. Place of Injury - At his building, etc. (Specif	ome, farm, street, fac y)	ctory, off	fice		28f. Location (Street and Number or Rural Route Number, City or Town, State)	i
		1						
29a. Certifier 1 Ce	rtifying Phys	Ician: To the best of my kno	wledge, death occu	rred at t	he time, o	date and place	and due to the cause(s) and manner as stated.	

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29b. Signature and title of certifier 29c. License number

23590

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SmITH ASHEEM AKHAM, MI) 31. Date filed (Month,

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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FEMALE:   23c. If yes, outcome of pregnancy   1		icate be physicia the bur	dical	d					
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The property of the control of the c	Υ ,	The lay					a	topsy prior to erformed? prior to	completion of cause of
State  28f. Location (Street and Number or Rural Route Number, building, etc. (Specify)  28e. Place of Injury - At home, farm, street, factory, office  28f. Location (Street and Number or Rural Route Number, City or Town, State)  28f. Location (Street and Number or Rural Route Number, City or Town, State)  29a. Certifier  29a. Certifier  29a. Certifier  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  31. Date filed (Month, Day, Year)  32. Registrar's Signature		nysiciai his certi I directo	o B	examiner?	2  ER/Outpatient	045		<del></del>	ecify)
29a. Certifier (Check only on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  State  31. Date filed (Month, Day, Year)  32. Fegistrar's Signature	0 0	th. : After t	ition:	1 Matural 5 ☐ Pending (Month, Day, Yea	(r) 28b. Time of Injury	28c. Injury at Work?	28d. Descrii		
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	, F	20 Vitt	2			29c. License nur	mber	29d. Date signed (Mon	th, Day, Year)
		21		30. Name and address of person who completed cause of death SUNGLES, W.D. 7901 W	(Item 23a) (Type, Pr	int) Tal	oma Parch	MAD 20	912
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** -ea /Medical 20/0 4a. Facility Name (If not institution, give street and number) Examiner Jown, or Location of Death 4c. County of Death Kandallstown Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Manth, Day) 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** 217.92.473 1 □ M 2 ▼ F Yrs Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Marical Everning is ust be muitied at 10d. Inside City Limits MD Director Baltimore Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? within 72 hours after death with USA Garrison Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 ☐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 þ 1 ☐Yes 2 No Specify 3 ☐ Widowed 4 ☐ Divorced Black Specify: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than' Elementary/Secondary (0-12) College (1-4or 5+) Private 12th grade Engineer mestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Melvin Louis 1112abeth ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2117 9206 Dwings Park Drive #C Owings Hills, MD Mother 20b. Place of Disposition (Name cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) any injury or King Memorial Dark 10 Windsor Mill, MD 10 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Vaushin C. Greene Funeral Sovices iberty Road Randalistown MD 21133 8728 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause of ach line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examine Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed as the burial-transi Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, physician Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 Month Day Year n signed by the a ld be detached fo Pregnant at time of death 5 Other (specify) 9 Hinknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Jnknown After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗆 No 1 □ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other (Spec Hospital: 1 Yes S No Other: 4 \( \sum \) Nursing Home Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 2 Accident 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: filled in by the 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifie cal and manner stated. 29b. Signature and title of sertifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and add ess of person who completed cause of death (Item 23a) (Type, Print

Registrar

State

31. Date filed (Month

ny

Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death MARCH Physician Year Henry J. King, Jr. 0457AM 2010 /Medical 4b. City, Town, or Location of Death
Bal Timore 4a. Facility Name (If not institution, give street and number) Examiner 4c. County of Death Acnes If I Inder 1 Year 8. Date of Birth
(Month, Day, Year)
Jul 27, 1937 5. Social Security Number If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 € M 2 □ F Months Days Hours 216-36-9359 72 Director California Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, it is Medical Examirat must be refitted in Director 1 ☐ Yes 2 ☐ No Maryland | Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8280 Railroad Ave. 21122 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 3 Widowed 4 Divorced 1 ☐ Yes 2 ☐ No If Yes, GiveX Year or Dates: Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Maintenance School School 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Henry J. King, Sr. Dorothy Garrison ပ Α. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy King/sister <u>6249 Deer Season Run</u> Columbia, MD 21045 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Mar₂₀₁₀13 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD Moreland Memorial Pk 21. Signature of Funeral Service 22. Name and Address of Facility Singleton Funeral and Cremation Lices <u>Services 1</u> 2nd Ave Sw Glen Burnie, MD 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner neumonici Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and Records, P.O. Box 68760 attending physician for use as the buria Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death Day Year signed by the a 1 □Yes 2 □ No 5 Other (specify) 9 Unknown significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy certificate 2 **D**No 2 No 1 □Yes 1 🗆 Yes Division of Vital Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No 1 npatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA completely filled in by the funeral . Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 □ No after death Director: 3 🗌 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier the 29b. Signature and title of certifier

10

State Registrar 30. Name and address

MAR 09 2010

22. Registrar's Signature

person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death . Decedent's Name (First, Middle, Last) Month Year Physician/ Larry Donnell Layne March 02. 0503 A 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Takora Montgarery Washington Adventist Hospital 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 € M 2 □ F 12/08/1956 Washington, D.C. 53 578-84-4790 Director Usual Residence of Decedent 10d. Inside City Limits of the state of th 10c. City, Town or Location 10a. State 10b. County filed within 72 hours after death with the Maryland Director 1X Yes 2 ☐ No PG Mt. Rainer MD 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number Funeral TISA 20712 4317 - 28th Place #4 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 XNo Black, White, etc þ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: Black Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Special Events Private should be filed with n and Mental Hygien 7 is marked other th 12th Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Susie Eaton Christopher Layne permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4317 28th Place #4; Mt. Rainer, Maryland 20712 Darhne Layne - Wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 🔀 Parial 2 🗆 Cremation 3 🗆 Removal from State 3/8/2010 Washington, D.C. Glenwood Cerretery Donation 5 Other (Specify) 22. Name and Address of Facility Freeman Funeral Services Sign f Funeral Service Licensee 4594 Beech Road; Temple Hills, Maryland 20748 Teem de Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Liver Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner (ancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Date to for as a consequence of The law requires that the death certificate be executed Cause (Disease or linjury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death Yes 2 No detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? Yes 2 No page 2 s 25. Was case referred to medical 26. Place of Death (Check only one) Hospital or Attending Physician: Be examiner? Hospital Other: 2 🗌 No ဥ 1 Inpatient 2 PR/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) To the Hospital or Attending Phy within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral! Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) building, etc. (Specify) Medical 1 Secritifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Dale signed (Month, Day, Year) 29b. Signature and title of certifier 52326 62 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20874 Emergency Med.Assoc. Germantown, MD James Kennedy Lightfoot, Jr 32/Registrar's Signat MAR 09 2010 Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 1327 LAFFERTY WILMER 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE BAYVIEW MEDICAL CENTER JOHNS HOPKINS If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Min. 1 🔀 M 2 🗆 F 74 Months 215-32-3007 Maryland Director September Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 Yes 2X No Maryland Baltimore Dundalk 10e. Street and Number 10f. Zip Code 109. Citizen of What Country? Funeral 21222 USA 8143 Bullneck Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? 1 X Yes 2 ☐ No If Yes, Give by 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) BGE 2 years Computer Operator 12 years other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) should be file and Mental F is marked of Helen M. Gosch Wilmer B. Lafferty 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2616 Greenspring Avenue, Joppa, Maryland 21085 19a. Informant's Name/Relationship (Type, Print) Department of Health an Important: If item 27 is any injury or other trainingnee. Frances Wilkenson sister Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State March 11. cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State Baltimore, Maryland Parkwood Cemetery 2010 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee connelly funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. Part 1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 3 PAYS Immediate Cause (Final Physician/ ARREST RESPIRATORY disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** WEEKS FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events HEART and I-transit Exami FAILURE CONGESTIVE that the death certificate be executed Due to (or as a consequence of) resulting in death) Last physician a Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year signed by the a d be detached f 2 🗌 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 V Unknown CONGESTION Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate ha irector, page 2 performed Yes 2 1 🗆 Yes 2 🗆 No I or Attending Physician: after death. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 M No 1 Inpatient 2 ER/Outpatient 3 DOA ပ After this 27. Manner of Death 1 ☑ Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation neral Director: / 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital within 24 hours a To the Funeral C completed filled Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier MD RES- 001 MARCH 7, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar HEFFERNAN, MD

31. Date filed (Month, Day, NAR 09

AVENUE

EASTERN

BALTIMORE, MD

4940

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical Examiner 9. Birthplace (State or Foreign Sex / 8. Date of Birth Funeral Director item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10b. County Director 1 Yes 2 No 10g. Citizen of What Country? 13 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 Dever Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🗹 No 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education Give kind of work done during most of working life. DO NOT use retired (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Be 17. Father's Name (First, Middle, Last should be file ၉ permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Baltimore, 20b. Place of Disposition (Name of 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear railure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ascular dementa Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner 1 aucoma Sequentially list conditions, Due to for as a consequence of cause. Enter Underlying Cause (Disease or iinjury burial-transi nemico and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as the b IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death for use 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? 5 Other (specify) signed by the a 1 Yes 2 Unknown 2 🗌 No 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown within 24 hours after death.

To the Funeral Director: After this certificate has been siy completed filled in by the funeral director, page 2 should to the funeral director to the function of the funeral director to the funeral director to the function of the funeral director to the function of the functi 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural (Month, Day, Year) 5 Pending work? 1 ☐ Yes 2 ☐ No L Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my original death occurred at the time. Medical 29a. Certifier 2 I Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and dddress of person who completed cause of death (Item 23a) (Type, Print) 20622 FRANCISCA 29449 CHARLOTTE CHARLOTTE BRUNEY 31. Date filed (Month, Day, Year) 32. Registra s Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #30 Per DVR C901 3/09/2010 IH State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 3:30 P M Faye Levy February 2010 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince Georges Heartfield at Bowie Bowie Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Sept 7, If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Hours Min. 1 □ M 2 💢 F 95 0klahoma 524-26-6323 Director Usual Residence of Decedent 10d. Inside City Limits 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinal must be notified at once. 1 ☐ Yes 2√ No Prince George's Director MD Bowie 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 7600 Laurel-Bowie Road 20715 USA Funeral Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married altimore, Maryland 21215-0036 1 □Yes 2 🔀 No Specify. Specify: white þ 3X Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation unk 15. Decedent's Education (Specify only highest grade completed) unk (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bettie Roberts Bernard Fabian Lewin ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Helena Stern/daughter 2100 Arrowhead Farms Ct Gambrills, MD 21054 Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ronald 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 22. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, if heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cruse (Final disease or condition resulting in death) Alsheimers **Physician** /Medical (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Exami and Due to (or as a consequence of) P.O. Box 68760, physician Physician/Medical attending physic for use as the b If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☑ No 5 Other (specify) signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 1 Yes 2 No 3 Probably 4 Unknown icate has been signated page 2 should b Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 2₽No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 ☐ Other (Specify) 1 ☐ Yes Certification: To 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? After t 1. Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death. e Funeral Director: A 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 Suicide 4 Homicide Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and son who completed cause of death (Item 23a) (Type, Print) 30. Name and address

State Registrar 31. Date filed (Month, Day, Year)

MAR 09 2010

Heartfield at Bowie

Bowie,MD 20715

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ 06^{Day} 2010^Y MARCH 5:14A SHIRLEY G. LERNER Medical 4a. Facility Name (if not institution, give street and number) Examiner County of Death BALT IMORE 4b. City, Town, or Location of Death GILCHRIST HOSPICE CARE TOWSON 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth 1 □ M 2**V**□ F Months Days Hours 84 Director 130-14-0117 Yrs Usual Residence of Decedent shov 10a. State 10b. County ural", or items 23a or 28a-f shore Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director OWINGS MILLS MD BALTIMORE 1 Tes 2XXNo 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral USA 4730 ATRIUM COURT, #447 21117 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. WHITE 1 ☐ Yes XX No Specify: "natural", 3X Widowed 4 □ Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) 72 (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the OWN HOME HOMEMAKER 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be file Ith and Mental H 27 is marked of traumatic ever ၉ ANNA SCHENK PAUL GAFFEN 19a. Informant's Name/Relationship (Type, Print) Department of Health an Important: If item 27 is any injury or other traumonce. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JAY LERNER/SON LIVELY STONE COURT, BALTIMORE, MD 21209 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State XX Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) TIMORE HEBREW 03/07/2010 REISTERSTOWN, MD 21. Signature of Funeral Service Licens 22. Name and Address of Facility SOL LEVINSON & BROS., 8900 REISTERSTOWN ROĀD, PĪKESVILLĒ, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physicianz Hapiretian disease or condition resulting in death) presmonia Medical Due to (or as a contequence of). Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): ng physician and as the burial-transit or Attending Physician; The law requires that the death certificate be executed Dause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Records, P.O. Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death nse 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No jo Month Day Year detached the g 🗌 Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ g 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 perform certificate Yes 2 X No 1 Yes Division of Vital 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? 1 🗆 Yes ဂ္ 2 XNo Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🔀 Other (Specify) 24 hours after death.
Funeral Director: After this eted filled in by the funeral dir 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Hospital Medical 29a. Certifier Karage Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou

To the Fune

completed file Medical Examiner: On the basis of examination and/or investigation, in my opinion is eath occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of dertifier 29d. Date signed (Month, Day, Year) D67286 Merch 6, 2010

DHMH 17 Rev 7/2009

State Registrar 30. Name and address of person who completed

William Fra

MD

21204

ause of death (Item 23a) (Type, Print)

6701 N.cher

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 125 Cherry Hill Road, Street, MD 21154 20c. Location - City or Town, State Pikesville, Maryland Burgee-Henss-Seitz Funeral Home, Inc. 21211
3631 Falls Road Baltimore MD
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as caldiac or respiratory arrest, shock, or heart
Approximate Approximate Interval Between Onset and Death 23d. Date of deliver Month Day 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) of Vital æ examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: Nursing Home 5 Residence 6 🗸 Other: Scene 1 🗸 Yes 2 No 28a. Date of Injury (Month, Day,Year) FOUND: After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Inhaled riding mower exhaust Natural FOUND: Pending 1 Yes 2 ✔ No Mar 1, 2010 1530 hrs Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 V Suicide Could not be or Town, State) 125 Cherry Hill Road, Street, MD determined (Specify) Enclosed shed Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated ca To the I within 2 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) O.C.M.E. March 2, 2010

1754 hrs

10d, Inside City Limits

1 Yes 2x No

Country)

White, etc.

Maryland

State Registrar

OCME 2006

DHMH 17 Rev 1/2001

**ORIGINAL** 

111 Penn Street, Baltimore, MD 21201

Assistant Medical Examiner

30. Name and address of person who completed cause of death (Item 23a)

Carol Allan, MD

31. Date file

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

			For State	State	of Marylar		artment of H		Mental Hy	giene		
			Registrar  1. Decedent's Name (First, Middle	Locati		Cer	tificate of D	Death		Reg. No. 2	010	-06960
	Physicia	n/	Lawrence	Kirkm	ıan	Larki	n		2. Date of Dea Month March	Day	010 Year	3. Time of Death  1:45 P M
	Medic Examin		4a. Facility Name (if not institution,			Darki		Location of Death			inty of Death	
	LAGITIT	٠.	Shady Grove A	dventist	Hospita	1	Rocky	ville			ontgon	
	Funeral		5. Social Security Number	6. Sex 1 <b>XX</b> M 2 □ F	7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt	th v. Year)	9. Birth	hplace (State or Foreign
	Director		578-22-6741 Usual Residence of Decedent	1 <b>/L/1</b> /VI 2 🗆 F	87	Yrs.			May 7,	1922	Mic	chigan
	and show lat	ō	10a. State 10b. County		10c. Cir	ty, Town or Loc	cation	·				10d. Inside City Limits
	Maryla 28a-f	Director	MD Mont	gomery			Rockvi	11e				1 ☐ Yes 2 X No
	a or a	Ö	10e. Street and Number				10f. Zip Code			-	of What Cou	-
	th with ms 23 must	Funeral	629 Azalea Dr.	Apt.1		0 40.0		20850	asife Van av Na		ted St	
· O	or ite	by F.	<ul><li>11. Marital Status</li><li>1 ☐ Never Married 2 X Marr</li></ul>	Armed Fo	edent Ever in U. orces? 2  No	li li	Vas Decedent of Hi FYes, specify Cuba	n, Mexican, Puerto	Rican, etc.)		Race - Ameri Black, White	
ဗ္ဗိ	rsafte iral", LExar		3 Widowed 4 Divorced	If Voc Cit	ve ates.WW II	. 1	☐ Yes 2XX No	Specify:		Sper	cify: Wh	hite
2-0	"natı "natı	plet		t's Education st grade completed	)	(Give I	lent's Usual Occupa kind of work done o		king	16b. Kind o	of Business In	ndustry
12	within 72 hours after death with the Maryland giene. ier than "natural", or items 23a or 28a-f sho is, the Medical Examiner must be notified at	Completed	Elementary/Seconday (0-12)	College (	I-4 or 5+)		ONOT use retired) onsultant	_		  Inter	nation	nal Business
ğ	I be filed w fental Hygi rked other tic event, t	Be	17. Father's Name (First, Middle, L	ast)				18. Mother's Nan	ne (First, Middle,	Maiden Surn	ame)	
ylar	ould be filed within 72 hours after death with the Maryland d Mental Hygiene. marked other than "natural", or items 23a or 28a-f show marke event, the Medical Examiner must be notified at	욘	Frederick	La	rkin			Eilee	n	Kir	kman	
Maryland 21215-0036	She is is		19a. Informant's Name/Relationsh				g Address (Street a					Code)
e,	and 2 s Health em 27 ther tra		Carlota Tulloc  20a. Method of Disposition	n / Daugr			8 Belgree	en Dr., A	Date		on - City or 7	Town State
nor	Page 1 nent of ant: If it ury or o		1 Burial 2 Cremation 4 Donation 5 Other (S	3 Removal from	. Chata	cemetery, cren	natory or other place	e) ory   3/5/	2010		•	le, MD
Baltimore,	permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr once.		21. Signature of Funeral Service L		M003		Name and Address			n Serv	ices	
m	P P E E		> Starter Start	Thena	<u></u>	9	33 Gist <i>A</i>	Ave., Sil	ver Spr	ing, M	D 209	910
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between Onset and Death											Interval Between	
7	Pnysician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a	Larynge		cer				_	Onset and Death
	Examiner			Due to	(or as a consequence Colitis							7 days
		iner	Sequentially list conditions, if any, leading to immediate	b. Due to	(or as a conseq							,,
	cuted nd transit	Examiner	Cause (Disease or linjury that initiated events	c								-
_	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	alE	resulting in death) Last	Due to	(or as a conseq	derice oi).						
760	cate by physics the	fedical		d								
89	oertif ending use a	an/N	IF FEMALE: 23b. Was decedent pregnant		tcome of pregna		Ectopic pregnanc	v		23d.	Date of deli	
80 0	death	by Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		gnant at time of		Other (specify)				Month	Day Year
Ö.	nat the ed by t detach	/ Ph	Part II. Other significant condition	ns contributing to	death but not re	sulting in the u	nderlying cause giv	en in Part I.	23e. Did t	obacco use c	ontribute to	the cause of death?
S,	uires the signer of signer								1 🗆	Yes 2 N	lo 3 🗆 Pr	robably 4 🔀 Unknown
Örd	w requ	Completed							24a. Was		1b. Were aut	topsy findings available completion of cause of
Be Se	The la ate ha page (	Som							perfo	ormed? 2X No	death?	2 □ No
ta	cian; sertific ector,	Be	25. Was case referred to medical examiner?	Hospital:			26. Pl	ace of Death (Chec	ck only one)			1
<u> </u>	Physical this carral direction	۲. ۲	1 L Yes 2 X No 27. Manner of Death	28a. Date	Inpatient 2  of injury	ER/Outpatier 28b. Time of	it 3 🗆 DOA	4 L Nursing H	ome 5 Resident			ify)
o uc	nding ath. : After e fune	icate	1X Natural 5 ☐ Pendir 2 ☐ Accident Investi	g (Moi	nth, Day, Year)	injury	work	? Yes 2□No	200. 2000/1201	low injury con	, d. 10 d	
Division of Vital Records, P.O. Box 687	r Atte ter de: rector	Certificate;	3 Suicide 6 Could 4 Homicide determ	inad 28e. Plac	e of Injury - At h ling, etc. (Specif		eet, factory, office		28f. Location (S		mber or Run	ral Route Number,
á	oital o nurs af eral Di											
	e Hos 124 ho e Fune	Medical	(Check 2 Medical E	Physician: To the xaminer: On the ba Nurse Practioner	sis of examination	on and/or invest	tigation, in my opinio	on, death occurred	at the time, date a	and place, and	due to the c	cause(s) and manner stated.
	To the within To the comp	2	29b. Signature and title of certifier	Nargo Tradudicio	TO THE DOST OF THE	ly talewiedge, c	29c. License			29d. Date sig		
							D.	58597		Marc	h 4,	2010
1	otly		30. Name and address of person					#206 P	ooksst 11 o	MD	20850	
X	Sta	e	Shahryar Davar 31. Date filed (Youth Day, Year)	32.	Registrar's Signa	ature		1/200, RO	JCKATTTE	, FID	20030	
	Registra	ar	31. Date filed Mark Day, Year)	170 Seres	me A		2					

DHMH 17 Rev 7/2009

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene.

		4	For	Department of Health and IVI Certificate of Death	entai mygieni Reg. No	0010	06061
			Negistrar  1. Decedent's Name (First, Middle, Last)		Date of Death     Month     Date	<del></del>	3. Time of Death
	Physicia /Medic		Gilbert Edward Moore		MHRCH 3	2010	8:20 P M
	Examin	er	4a. Facility Name (If not institution, give street and number)  22 29 Rolldwin Mill Rd	4b. City, Town, or Location of Death	40	County of Death	
J. 17	Funeral		5. Social Security Number 6. Sex, 7. Age (In yrs. last birt	The state of the s	8. Date of Birth (Month, Day, Year	9. Birthpla	ce (State or Foreign
	Director		011-10-0869	Yrs. World's Days (Tours Will)	Sept 14, 19	al mai	ryland
	land ow		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town	or Location		100	I. Inside City Limits
	Mary a-f sh	ctor	PA York	Airville			1 ☐ Yes 2 🕅 No
	or 28	Director	10e. Street and Number	10f. Zip Code	10g. C	itizen of What Country	n La los
	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ent, the friediest Econium must be notified at	Funeral	12 Mitchell Koac	13. Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto I	cify Yes or No-	14. Race - America	
9	or item		Armed Forces?	If Yes, specify Cuban, Mexican, Puerto I  1 ☐ Yes 2 ☑ No Specify:	Rican, etc.)	Black, White, etc	
) 0 3	ours a	d by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:		165	Specify: Who	te
21215-0036	n 72 h I "natu Iorlica	Completed	(Specify only highest grade completed)	Decedent's Usual Occupation (Give kind of work done during most of workin life. DO NOT use retired)		arris	Sity
212	d withi	mo	Elementary/Secondary (0-12) College (1-4or 5+)	Electrician		onstruc	tion
p	be filed tal Hy d othe event,	Be	17. Father's Name (First, Middle, Last)		(First, Middle, Maide		
Maryland	d Men narke	ဍ	George F. Moor 19a. Informant's Name/Relationship (Type. Print) 19b	. Mailing Address (Street and Number or Rura		or Town. State. Zip C	Code)
Z	nd 2 sh Ilth an 27 is r r traur		James Moore - Nephew 12	1 Mitchell Roac	1. Airvi	Ile PA IT	302
ē,	s 1 ar		20a. Method of Disposition 20b. Place of cameter			Location - City or Tow	n, State
altimore,	Page ment c ant: If ury or		More More	Cemeteri 3/6	12010 15	altimor	e, mb
Balt	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the five field Examination once.		21. Signature of Funeral Service Licensee	22. Name and Address of Facility	rapei + Cr	emation?	Services
	402 40		23a. Part 1. Enter the disease, or complications that caused the death. Do	3 New port Drive	or respiratory arrest,		Approximate Interval Between
4	Physician	6 5	shock, or heart failure. List only one cause on each line. Immediate Cause (Final				Onset and Death
	/Medical		disease or condition resulting in death)  a. Due to (or as a consequence	2			
	Examiner	-	Sequentially list conditions, if any, leading to immediate  b. Due to (or as a consequence	oft:		^	2495
	uted 1 Insit	Examiner	Cause (Disease or injury	01).		2	days
o,	an and	Exa	resulting in death) Last  C. Due to (or as a consequence	of):			
68760,	eath certificate be executed attending physician and for use as the burial-transit	edical	d				
	certific	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy	_		23d. Date of deliver	·y
. Box	requires that the death certi neen signed by the attending hould be detached for use a	Physician/M	23b. Was decedent pregnant in the past 12 months?  1 ☐ Yes 2 ☐ No  1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	n 3 ☐ Ectopic pregnancy 5 ☐ Other <i>(specify)</i>		Month	Day Year
P.O.	at the d by th etache	Phys	9 ☐ Unknown  Part II. Other significant conditions contributing to death but not resulting i	n the underlying cause given in Part I	23e. Did tobacc	o use contribute to the	e cause of death?
	w requires that the desired speed is been signed by the should be detached		Chromic a. Lib	if the underlying cause given in that i.		2 No 3 Proba	
S		Completed by	Dm		24a. Was an	24b. Were autop	sy findings available
Re	The law te has b	dmo	CAD		autopsy performed′ 1 □ Yes 2 □	death?	npletion of cause of 2 □ No
ita	ysician: The ils certificate h director, page	Be	25. Was case referred to medical	011	h (Check only one)		
Division of Vital Records,	Attending Physician: The r death. ector: After this certificate h by the funeral director, page	မ	1   Yes 2	·	me 5 Residence	6 ☐Other (Specify iury occurred	ALF
o	th. ; After funel	tion		Injury Work? M 1 ☐ Yes 2 ☐ No		. ,	
Visi	- Atter er dea rector by the	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, for building, etc. (Specify)	arm, street, factory, office	28f. Location (Street City or Town, St	and Number or Rura ate)	Route Number,
Ö	urs afte ral Dir			and add accounted at the time date and place	and due to the eaus	n(c) and manner as s	tated
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director; After th completely filled in by the funeral	Medical	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge 2 Medical Examiner: On the basis of examination a and manner stated.	nd/or investigation, in my opinion, death occur	red at the time, date	and place, and due to	the cause(s)
	To the within 2 To the comple	Mec	29h Signature and title of certifier	29c. License number		Date signed (Month,	Day, Year)
			I Want King no	D 31245		3/5/10	
			30. Name and address of person who completed cause of death (Item 23a)  Wendy Kloss 2 m 0 57-61 Kin	(Type, Print) word Ave But m	0 2006		
	Sta	ato.	31. Date filed (Month, Day, Year) 32. Registrar's Signature	21	ر در د		
	Segist		MAR 09 2010 Gener J. Jan				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Year 2010 10:52PM 26 Rose M. Miller February Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Worcester Berlin Nursing & Rehab Berlin If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Hours New York 1 M 2 X F 1933 77 Director 057-28-8951 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State with the Maryland Director "natural", or items 23a or 28a-f s edical Examiner must be notified 1 Yes 2 No MD Newark Worcester 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21841 USA 8520 Marshall Creek Road Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 Yes 2 A No Black White etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: white Yes, Give 3 Widowed 4 X Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ Mary Francis Dembowski Clayton Coons 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8520 Marshall Creek Road Newark, MD 21841 Nancy Miller/daughter Σ 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 Other (Specify) 21. Signatur of Fig. + rvice License on a 1 d. S. 22. Name and Address of Facility State Anatomy Baltimore, MD Board 655 W. Baltimore Street **∉**ctor 23a. Part \ Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Immediate Oause (Final disease or condition resulting in death) Onset and Death Priysician/ Medical Due to (or as a conse mence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) nding physiciar Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 as nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy atten in the past 12 months?
1 Yes 2 No jo Pregnant Unknown Year Pregnant at time of death 5 Other (specify) ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? been signed the should be detected to the sh þ 1 X Yes Division of Vital Records, 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 \( \subseteq \text{ Yes} \) 2 \( \subseteq \text{ No} \) 24a. Was an autopsy performed? Yes 2 No page 2 s Jas certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 2 **X**No မ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred hin 24 hours after death.

the Funeral Director: After impleted filled in by the funeral injury 1 XNatural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check The control of the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2

To the F

complet only one

State Registrar

29b. Signature and title of certifier /

Pennie Savage, CRNP,

MAR 09 2010

9715 Healthway Dr, Berlin,

rack

address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Sign

29d. Date signed (Month, Day, Year, March 1, 2010

21811

			For State	State of Maryland / Department of Health and Mental Hygiene  Certificate of Death  Reg. No. 2 1   1   1   1   5   9										0606		
વર્ષ	Physici		Decedent's Name (First, Middle, Last)					2				2. Date of Death Month Day Phylogy 210 2010 1855				
	/Medio		4a. Facility Name (If not institution, give street and number)  The Johns Hopkins Hospital				4b. City, T	City			4c. County of Death					
ie.	Funeral Director		5. Social Security Number  infant  Usual Residence of Decedent	6. Sex 1   M 2 □ F	7. Age (In yrs. las	Yrs.	If Under Months	1 Year Days	If Under Hours	Min. 23	8. Date of B (Month, D Feb 26	year)	10	Count	lace (State or Foreign ry) yland	
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland tt of Health and Mental Hyglene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	rector	10a. State 10b. County MD  10e. Street and Number	Town or Lo						10a Citi	zen of Wi		10d. Inside City Limits 1    Yes 2   No  Country?			
		by Funeral Director	527 N. Belford Avenue  11. Marital Status  1 ☒ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced  12. Was Decedent Ever in U.S Armed Forces?  1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:				21205  13. Was Decedent of Hispanic Origin? (Specify Yilf Yes, specify Cuban, Mexican, Puerto Rican,					USA s or No- 14. Race - American Indian				
21215-0036	filed within 72 hour Hygiene. other than "natural" ent, the Medical Exi	Completed b	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4 or 5+)  infant infant			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  infant						16b. Kind of Business/Industry  infant				
Maryland	l 2 should be file and Mental Hy is marked oth raumatic event,	To Be (	17. Father's Name (First, Middle, Joseph Drew	Last)							e (First, Middi eka Mod		den Surname)			
Baltimore, Mary	The law requires that the death certificate be executed beyond the has been signed by the attending physician and lapton be detached for use as the burial-transit one once.		19a. Informant's Name/Relations The Johns Ho		pital		-	,			ral Route Num timore,		or Town, S 212		Code)	
			20a. Method of Disposition  1  Burial 2  Cremation  4  Donation 5 Tother (S		State <i>cer</i>		osition (Nam matory or oti		9)	I	Date	20c. Lo	cation - (	City or To	wn, State	
Balti			21. Signature of Ronald Scenses and Director State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201										Approximate Interval Between			
			show or heart failure. List of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions,	a,	(or as a conseque		· D	se n	nat	uri	+c1.				Interval Between Onset and Death	
Division of Vital Records, P.O. Box 68760,		dical Examine	fany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consect c.  Due to (or as a consect d.			•									
		Physician/Mec	IF FEMALE: 23b, Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live I	tcome of pregnand birth 2  Fetal of nant at time of dea nown	déath 3	Ectopic pr Other (spe				· · · · · · · · · · · · · · · · · · ·		23d. Date Mor	e of delive	ery Day Year	
		þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause give							en in Part I. 23e. Did tobacco use co				antribute to the cause of death?  3  Probably 4  Unknown		
		Completed						24a. Was an autopsy performed?  1 \[ Yes \] 27 \[ No \] No \[ 1 \] Yes \[ 2 \] No			mpletion of cause of					
	siclan: Th certificate director, pa	To Be										<i>(</i> )				
	To the Hospital or Attending Physician: The layinin 24 hours after death.  To the Funeral Director: After this certificate hat completely filled in by the funeral director, page		27. Manner of Death 1 Natural 5 Pending (Month, Day envestigation) 2 Accident 28a. Date of Injur (Month, Day			28b. Time of 28c. Injury at				28d. Describe how injury occurred						
		Certification:	3 Suicide 6 Could 4 Homicide determ	ined buildi		arm, street, factory, office				28f. Location (Street and Number or F Cify or Town, State)						
	he Hosph in 24 hour he Funers ipletely fills	edical	29a. Certifier (check only one)  1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place 2. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2. Medical Examiner: On the basis of examination and occurred at the time, date 2. Medical Examiner: On the basis of examination and occurred at the time, date 2. Medical Examiner: On the basis of examination and occurred at the time, date 2. Medical Examiner: On the basis of examination and occurred at the time, date 2. Medical Examiner: On the basis of examination and occurred at the time, date 2. Medical Examiner: On the basis of examination and occurred at the time, date 2. Medical Examiner: On the basis of examination and occurred at the time, date 2. Medical Examiner: On the basis of examination and occurred at the time, date 2. Medical Examiner: On the basis of examination at the time at the								ce, and due to the cause(s) and manner as stated. curred at the time, date and place, and due to the cause(s)					
	70 t with 70 tl	Ž	29b. Signature and title of certifie			,	29c.	RE.	10 number	00			_		Day, Year)	
}			30. Name and address of person	ŕ	· ·		·			600	North W		,		e, MD, 2128	
	Sta Registi		31. Date filed (Month, Day, Year)	010 Sen	egistrar's Signatu	for	RI									

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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TITEM#200, perffl, G901, 3/17/2010, WS

State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 06964 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MENNELLA Physician/ ANITA Month 2010 M920550 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death HILLSIDE HOUSE ASSISTED LIVING CLARKSVILLE HOWARD 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F Months Days Hours Min. 03/975/1927 82 Director 130-20-7525 NY Usual Residence of Decedent or 28a-f show notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director HOWARD CLARKSVILLE 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a or the Medical Examiner must be Funeral 5502 HARRIS FARM LANE 21029 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2XX No Specify: WHITE 3 X Widowed 4 □ Divorced 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ **EDYTHE** J0E ROSENBERG 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 181 W. 238TH ST., BRONX, NY CHRISTINE O'ROURKE/NIECE 10463 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr once. 20a. Method of Disposition 20b. Place of Disposition (Name of 08^{Date} 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 X Removal from State MT. CARMEL CEMETERY 03/<del>07/</del>2010 IGLENDALE, NY 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD, PIKESVILLE. MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final SEPTIC SHOCK Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner PERFORATED VISCUS Sequentially liet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of): PNEUMONIA BALT To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi Due to (or as a consequence of): Physician/Medical STROKE PAST Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ PAILURE Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown HYPERTENSION 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No death? DYSUPIDEMIA 1 🗌 Yes 2 🗆 No completed filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 4 Nursing Home 5 Residence 6 Pother (Specify) LIVING 2 XNo Other: 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Investigation 6 Could not be ☐ Accident hours after deat neral Director: Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a To the Funeral I Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier PHYSICIAN 0062704 FILICHT GIM, MD 21043 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3290 N. Ridge Road. KARTIK MEDA MD 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death March 5, 2810 Physician/ 5:15 P™ Jay Mulqueen, Sr. Michael Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Frederick Ijamsville 5614 Broadmoor Terrace North 8. Date of Birth 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 1^{Year)} 1<u>934</u> **Funeral** Days Sept. 11, Hours New York 1 🛛 M 2 🗆 F 75 Director 058-26-4019 Usual Residence of Decedent 10d Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must he notified at and Mental Hygiene.
I is marked other than "natural", or items 23a or 28a-f show
I is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10a. State 10b. County Director 1 ☐ Yes 2X No Cockeysville MD Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21030 USA 10502 Pot Spring Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. ð 1 Never Married 2 Married 1 X Yes 2 If Yes, Give 2 🗌 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Specify: White Year or Dates. 53 -55 Completed 3 ☐ Widowed 4 🏋 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education Composition Co. (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) 5+ Typesetting Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Sarah A. Glover Michael M. Mulqueen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5614 Broadmoor Terrace North Ijamsville, MD 21754 Michael J. Mulqueen, Jr./Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 3/10/10 1 X Burial 2 Cremation 3 Removal from State Dulaney Valley Memorial Gardens Timonium, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funer Lemmon Funeral Home of Dulaney Valley, 10 W. Padonia Road Timonium, MD 21093 Hierael J. Flagle 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Disease Immediate Cause (Final 2 Years Phylician/ disease or condition resulting in death) Medical Far Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury attending physician and for use as the burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death signed by the at d be detached for 1 Yes 2 L 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes 24 hours after death.

24 hours after death.

6 Funeral Director. After this certificate has been single Funeral Director, page 2 should Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending 1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 8-10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month,

Cockeysville, MD 21030

John Simon, M.D. 54 Scott Adam Road

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 0020M 2010 Medical 4a. Facility Name (if not institution, give street and number) or Location of Death 4b. City 4c. County of Death **Examiner** If Under 24 Hrs. 8. Date of Birth Age (Ir Funeral Aug Z Yrs. Director Usual Residence of Decedent Department of Health and Mental Hygiene. Important; or items 23a or 28a-f show Important; If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hyglene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County Town or Location 10d, Inside City Limits Completed by Funeral Director 1 XYes 2 ☐ No 10e. Street and Number 10g. Citizen of What Country? 21 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 Never Married 2 Married 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Indust (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, 18. Mother ပ္ ore Informant's Name/Relationship (Street and Number or Bural Route Number, City or Son 0 20a. Method of Disposition 20b. Place of Disposition (Name of 200 🗴 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service License (Z1229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Cancer ung disease or condition resulting in death) Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): been signed by the attending physician and should be detached for use as the burial-transit Cause (Disease or liniury Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Other (specify) Pregnant at time of death 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Tes 2 No 3 Probably 4 Wunknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform has page 2 this certificate 1 Tes 2 🗌 No 25. Was case referred to medical examiner? completed filled in by the funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No Certificate: To 1 🗌 Yes 1 Nnpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After 1 Natural injury work? 1 ☐ Yes 5 Pending 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/  $2010^{\text{Year}}$ March 11:52a Leslie K. Nakamura Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner Anne Arundel 824 Riverside Drive Pasadena If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) Country) Hawaii **Funeral** (Month, Day, Year) Hours Min. 1 🔀 M 2 🗆 F Director 575-32-9853 77 Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or items 23a or 28a-f sho edical Examiner must be notified at Director 1 Yes 2 XNo Maryland Anne Arundel Pasadena 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 21122 United States 824 Riverside Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 72 hours after death 12. Was Decedent Ever in U.S 14. Race - American Indian Armed Forces? 1954-Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 1976 Specify: Asian Completed 3 Widowed 4 Divorced the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) United States Army Army Officer permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, th Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Harold Nakamura Tomiko Tanaka 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 824 Riverside Drive, Pasadena, Maryland 21122 Katherine S. Nakamura, Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State March Bat. 1 Burial 2X Cremation 3 Removal from State Metro Crematory, Inc. 2010 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Amanda Heaston 22. Name and Address of Facility MacNabb Funeral Home, P.A. 301 Frederick Road, Catonsville, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Metastatic Cancer Physician/ year disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Cause (Disease or linjury that initiated events the burial-transi and Due to (or as a consequence of) ŵ resulting in death) Last attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? 5 Other (specify) Pregnant at time of death signed by the a Yes 2 No 1 ☐ Yes 2 L 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown Completed миет this certificate has been si funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate is completed filled in by the funeral director, page 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? ည 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury work?
1 Yes 2 No 1 X Natural 5 Pending Accident 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 🖄 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

15+1

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Res-

2010

El, Medical Doctor

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month Physician 2016 URROL /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number, Examiner MORE 921 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number **Funeral** Year) Min. Months Days 1 ☐ M 2 🕢 F 40-3169 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show Examiner must be notified at 1 ☐ Yes 2 Tho Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. ant: If Item 27 is marked other than "natural", or items 23a or ury or other traumatic event, the Medical Examiner must be It Funeral Was Decedent Ever in U.S Armed Forces? . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 2 No if Yes, Give Year or Dates: 1 ☐ Yes 2 PNo Specify: White Baltimore, Maryland 21215-0036 Specify. þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) UNION TRUST BANK BANKER NA 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ို (9b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mowery (Daughter CORO 20b. Place of Disposition (Name of cemetery, crematory or other place) Dațe 20c. Location City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any injury or ot
once. March 10 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2010 21. Signature of Fungral Service Licens@ Cho, TNACKI FUN 1005 Dandalk HARY/AND ZIZIZY 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. pproximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) YEARS Bladder Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Litter bruterlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and as the burial-tra Due to (or as a consequence of): P.O. Box 68760. physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Year Day in the past 12 months? 5 ☐ Other (specify) 4☐Pregnant at time of death 1 ☐ Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. Records, <u></u> 1 | Yes 2 | No 3 | Probably 4 #Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No 1□ Yes Division or Vital 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 P No 1 🔲 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b Time of 28c. Injury at Work? After Injury 5 Pending investigation 1 Matural within 24 hours after occur.

To the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature a 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) oital 1.40

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] Certificate of Death 3. Time of Death Date of Death 1. Decedent Name (First Middle, Last) **Physician** 1 A /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Randallstown Seasons Hospice Birthplace (State or Foreign Country) f Under 1 Year | If Under 24 Hrs Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** Days Months Hours 1 ☑ M 2 ☐ F 1927 Washington, D.C. 82 16, Director 578-42-2199 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland 10a. State 10b. County item 27 is marked other than "natural"; or items 23a or 28a-f show other traumatic event, the "wadgal Examinal in ust be notified at 1 ☐Yes 2 ☑ No Director Maryland Havre de Grace Harford 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21078 2100 Williams Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or Items 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 🖾 No Specify Specify: Black ð 3 XWidowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Military U.S. Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) pe . Pages 1 and 2 should be Iment of Health and Ments In item 27 is marked Louise (unk) Dennis Theodore Jesse Nickens Sr. 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1017 Tripple Bar Ct., Henderson, NV 89002-9443 Robert D. Nickens Brother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) od of Disposition 20a urial 2 Cremat Injury or permit. Page Department of Important: If any Injury or Baltimore, Maryland 5 Othe zon Forest Cem. 3-17-10 cify) Name and Address of Facility
McComas Funeral Home, P.A. 317 Cokesbury Rd., Abingdon, MD 21009 Approximate Interval Between not enter the mode of dying, such as cardiac or respiratory arrest, Par 1. Enter the disease shock, or heart failure. Onset and Death Immediate Cause (Final disease or condition resulting in Leath) -Physician /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner been signed by the attending physician and should be detached for use as the burial-transit executed Due to (or as a consequence of) P.O. Box 68760, pe Physician/Medical The law requires that the death certificate IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ð 1 Yes 2 No 3 Probably A Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b irector, page 2 sl autopsy 2 **M**No 1 ☐Yes 2 ☐ No 1 ☐ Yes To the Hospital or Attending Physician: 26. Place of Death (Check only one) director. 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 1 Yes 2 2 2 2 2 2 2 2 2 2 2 2 ER/Outpatient 3 DOA 1 Inpatient Other (Specify this Certification: To funeral Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After Natural 5 Pending s after death.

I Director: After in by the fur 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 ☐ Homicide 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 1/2001

State

er and address of person who completed cause of death (Item 23a) (Type

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#19aperFH.G901 3/16/2010 WS
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 3, 2010^{Year} Physician/ Piendak George Α. March 4:45 P M Medical 4a. Facility Name (if not institution, give street and number 3401 Greenway Apt # 202 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore If Under 1 Year If Under 24 Hrs 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex **Funeral** Month, Day, Year) March 13,1944 1 🗓 M 2 🗆 F Months Days Hours Min Connecticut Director 046-34-5889 65 March Usual Residence of Decedent 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evaminar must be accessed. 10d. Inside City Limits 10a. State 10b. County Funeral Director Baltimore 1 Yes 2 No MD N/A 10f. Zip Code 21218 10e. Street and Numbe 10g. Citizen of What Country? 3401 Greenway Apt # 202 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White 3 → Widowed 4 □ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired)
Budget Director Elementary/Seconday (0-12) College (1-4 or 5+) Baltimore City Gov't Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Eugene L. Piendak Genevieve T. Pilewski 19a. Informant's Nam**y** Be<del>ldinis</del>hio (17*pe, Print)* Emily A. <del>Vainier</del> / Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) St. Baltimore, MD 21218 2640 N. Calvert 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 3/10/2010 Hillton Serv. Corp. Towson, Maryland Towson, Maryland 21204 22. Name and Address of Facility 21. Signature of Euneral Service Ruck Towson Funeral Home, Inc. 1050 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Imorary Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy
Pregnant at time of death 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 1 Yes 2 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? pertensia 24a, Was an autopsy Yes 2 No 1 Yes 2 No To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes Hospital: Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 Yes 2 No Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier The deficial Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier > 00634

Registrar

State

30. Name and address of pe

31. Date filed (Month, Day, Year)

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM# 20b perFH, G901, 3/16/2010, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death OB Day **Physician** 2010 11:30 AM William A. D. Parker, Jr. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Baltimore Towson 205 E. Joppa Road If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10/31/1918 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min 1 M 2 □ F 91 MD 214-16-9862 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evantual must be notified at once. 10b. County 10c. City, Town or Location 10d Inside City Limits 10a. State 1 ☐ Yes 2 🔀 No Director MD Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? #301 USA 21286 205 E. Joppa Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 XIYes 2 □ No If Yes, Give Year or Dates: WWII 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: white à 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Sales Representative Sales 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William A. D. Parker, Sr. Delphine Colburn ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda C. Fowler/ daughter 202 Brightdale Road, Timonium MD 21093 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 3/9/2010 Towson, MD 22. Name and Address of Facility Towson, MD 21204 21. Signature of Funeral Service Licensee Ruck Towson Funeral Home, Inc. 1050 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pulmonar **Physician** 5 years disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the hurial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Year Day 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 ☐Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Besidence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Natural 2 Accident 5 Pending after death.

I Director: Af in by the fur investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Detertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) R110361 2010 XO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lock Raven Blud Baltimore 3900 Debovah LUBON 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ^{Day} 2010 Charles G. Prodey 11:06 pm March Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 150 N. Decker Ave. Baltimore Social Security Number 215–12–9226 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral 9. Birthplace (State or Foreign 1 💢 M 2 🗆 F Months Days Hours Country) 86 0372871923 MD **Director** Usual Residence of Decedent ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director MD Baltimore YYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 150 N. Decker Ave. 21224 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Press Operator Printing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Anthony Prodey Augustus Peterson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Prodey / Wife 150 N. Decker Ave., Baltimore, MD 21224 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Oaklawn Cemetery 03/12/2010 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rendon-Bailey Funeral Home, PA 21. Signature of Juneral Sc 2818 E. Baltimore St., Baltimore, MD 21224 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition resulting in death) 2 llears Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): law requires that the death certificate be executed use as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Division of Vital Records, P.O. Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? page 2 should be detached for Month Day Year Pregnant at time of death the 1 L Yes 2 L 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes this certificate has been 24b. Were autopsy findings available 24a. Was an autopsy performed? Yes 24 No prior to completion of cause of death? Hospital or Attending Physician; The 1 ☐ Yes 2 ☐ No 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 🖁 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28d. Describe how injury occurred After (Month, Day, Year) injury 1 Natural 5 Pending To the Hospital or Attendii within 24 hours after death, To the Funeral Director: Af 2 Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Curtifying Number Praction on T. the content of my hours of state of the cause of (Check snlv one 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

MAR 09 201

Baltimore, MD 21287

pleted cause of death (Item 23a) (Type, Print)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician ARKER-BRANCH Month GELA . 20 A M 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Future Care Charles Village Baltimore N/A 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2**X** F Months Hours Min. 218-64-0820 54 NOV 18, Director Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertial Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other thaumatic event, In Medical Evanime must be notified at any injury or other traumatic event, In Medical Evanime must be notified at 10d. Inside City Limits 10c, City, Town or Location 10b. County Director 1 ☐ Yes 2 No Catonsville MD Baltimore 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? USA 945 Southridge Road 21228 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ģ Specify: 3 X Widowed 4 ☐ Divorced **Black** Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Nursing Assistant Nursing Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Gary Parker Sylvia ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 945 Southridge Road Catonsville, MD Nicole M. Parham, daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 03/08/10 Baltimore, MD 21. Signature of Funeral Service Licensee George MacNabb 22. Name and Address of Facility Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final lance **Physician** disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Physician/Medical þ Completed Be

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Division of Vital Records, P.O. Box 68760, within 24 hours are, ....
To the Funeral Director: A

resulting in death) Last		Due to (or as a conseg	us nce of):							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes No 9 Unknown  23c. If yes, outcome of pregnancy 1  Live birth 2 Fetal death 5 Other (specify)									lelivery Day	Year
Part II. Other significant condit	i <b>ons</b> cor	ntributing to death but not res	ulting in the underly	ing caus	se given in Part I.		Did tobacco	use contribute	to the cau	use of death?
							Was an autopsy performed?	prior to death?	completi	ndings available on of cause of
25. Was case referred to medica	al				26. Place of De	ath (Check	only one)			
examiner? 1 ☐ Yes 2 ☐ 40	F	lospital: 1   Inpatient 2	Other						necify)	
27. Manner of Death Natural 5 ☐ Pending 2 ☐ Accident investigation		28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M		. Injury at Work? 1 □Yes 2 □No	28d. Describe how injury occurred				
3 ☐ Suicide 6 ☐ Could deterr		28e. Place of Injury - At he building, etc. (Specification)	ome, farm, street, fa	ictory, o	ffice		tion (Street a or Town, Stat	nd Number or le)	Rurai Rou	te Number,
29a. Certifier 1 Certifyi (Check only one) 2 Medica	ing Phy	sician: To the best of my kno ner: On the basis of examina and manner stated.	owledge, death occu ation and/or investig	urred at ation, in	the time, date and plan my opinion, death occ	ce, and due to	to the cause( time, date ar	s) and manner nd place, and d	as stated. ue to the o	cause(s)
29b. Signature and title of certific	er 🔥	0		29c. L	icense number		29d. D	ate signed (Mo	nth, Day,	Year)

State Registrar

Certification: To

Medical

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] | [] Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Annabelle Pilli March 8 2010 1:10 a^M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 303 Maiden Choice Lane, Apt. 116 Catonsville Baltimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. . Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 □ M 2 🏅 F Dec. 12, Year 220-12-6957 Director 1925 Maryland Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Catonsville Maryland Baltimore 10e. Street and Number 10g. Citizen of What Country? Funeral 21228 United States 303 Maiden Choice Lane Apt 116 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 1 Never Married 2 Married "natural", or Completed by 3altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Cleveland Fincham Marie Strosnider 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 shand Department of Health ar Important: If item 27 is Antionette Pilli/ Daughter 99 South Symington Avenue, Catonsville, Maryland 21228 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Marchat8. 1 🗆 Burial 2 🛣 Cremation 3 🗆 Removal from State injury or Metro Crematory, Inc. Baltimore, Maryland 4 Donation 5 Other (Specify) 2010 Signature of Fluneral Service Licensee Aman a Heaston 22. Name and Address of Facilit Cremation Society of Maryland, Inc. 299 Frederick Road, Baltimore, Maryland 21228 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine il any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of sician and burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical attending physic for use as the b IF FEMALE yes, outcome of pregnancy
Live Birth 2 D Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Pregnant at time of death 5 Other (specify) signed by the a Unknown g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 2 No Yes filled in by the funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? 2 🛛 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manufer of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5  $\square$  Pending Matural Natural wark? 1 Yes Investigation 6 Could not be Accident 2 Accident
3 Suicide
4 Homicide 24 hours after deat Funeral Director; 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Number Praction or To the local of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier within 24 hou To the Fune completed fi To the 3 - Gertifying Nurse Practioner To the best of my knowledge, door 29b. Signature and title of gertific 29c. License number 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) 30. Name and address of suitell cutorsville 21228 31. Date filed (Month, Day, 32. State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 06975 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month 3 Physician/ Norwood 35 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death N/A Joseph Richey Hospice Baltimore 8. Date of Birth (Month, Day, Aug. 29, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 24 Hrs. **Funeral** Maryland Months Days Hours Min. 214-64-8603 53 Director Usual Residence of Decedent or 28a-f shov notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland **Baltimore** Gwynn Oak 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be Funeral 21207 3219 Brightwood Avenue United States 12, Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. Š 1 X Never Married 2 Married 1 Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black Completed 3 Widowed 4 Divorced Year or Dates er than "natur , the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other tha any injury or other traumatic event, the N Self Employed Freelance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Norwood Pope Lillie Fulton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pope/Son Tivese 1808 E. 30th Street, Baltimore, Maryland 21218 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State March 9, 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. Baltimore, Maryland 2010 21. Signature of Funeral Service-Licensee Amanda Heaston 22. Name and Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or linjury been signed by the attending physician and should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown 4 ☐ Pregnant : 9 ☐ Unknown 5 Other (specify) Month Dav Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Circhodij 2 No 3 ☐ Probably 4 ☐ Unknown Records, 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an page 2 autopsy performed After this certificate 25. Was case referred to medical examiner?

1 Yes 2 No Vital completed filled in by the funeral director, æ 26. Place of Death (Check only one) Other: ျ Hotorce 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1\Natural 5 Pending 2 ☐ Accident 3 ☐ Suicide s after death Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) 24 hours a Funeral I Medical 29a. Certifier 🔟 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) 4006426 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Balt 140. 21201 State

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year <u>Virginia Lo</u>uise Pendleton 0530 FM MARCH Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Union Memorial Hospital Baltimore N/A Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth 24 Hrs. Birthplace (State or Foreign Country) **Funeral** (Month, Day, Y 1 □ M 2X□ F Days Months Hours Min. Director 93 212-03-0456 1916 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location notified at 10d. Inside City Limits Director 28a-f 1√2 Yes 2 ☐ No N/A Maryland Baltimore 10e. Street and Number 10f. Zip Code ms 23a or must be 10g. Citizen of What Country? Funeral 1922 Lauretta Avenue 21223 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. þ ö 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give filed within 72 hours after Maryland 21215-0036 1 ☐ Yes 2x No Specify. Black "natural" Completed 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Housewife Own Home Unk. 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Edward Matthews traumatic Clara Groomes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health Paula Green/ Niece Coldspring Lane Baltimore, MD 21215 Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State ö 1 Burial 2 🔀 Cremation 3 🗌 Removal from State Department of Important: If any injury or 4 Donation 5 Other (Specify) 3/13/10 Baltimore, Maryland reenmount Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Chatman-Harris Funeral Home Harris <u> 5240 Reisterstown Rd Baltimore,MD 21215</u> 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) HEART FAILURE CONGESTIVE YEARS Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): sician and burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 Fetal death
Pregnant at time of death in the past 12 months?

1 Yes 2 No
9 Unknown Month Day by the be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? Yes 2 No death? certificate 1 Yes Division of Vital To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical or Attending Physician: Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No hours after death. Accident Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) To the Hospital within 24 hours a To the Funeral C Hospital Medical 29a. Certifier 1🄽 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

Registrar DHMH 17 Rev 7/2009

State

1600

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MAR 09 2010

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31. Date filed (Month, Day, Year)

MD,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Box 68760

P.O.

EAST UNIUBREIT?

29c. License number

AU4176435D19843

UNION MBMORIAL

BALTIMORE, MD

29d. Date signed (Month, Day, Year)

MARCH 05 2010

HOSPITAL

10-01881

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Dennis Podles	State of 1-For State Registrar	Maryland / Depa <i>Cer</i>	rtment of tificate of		Mental H		eg. No. 20	10 06977
Physician/ Medical Examine	Decedent's Name (First, Middle,Last)		Podl	es		2. Date of Dea Month March 6, 2	th Day Year	3. Time of Death 1111 hrs
	4a. Facility Name (if not institution, give str Johns Hopkins Bayview Medi		4	b. City, Town, or L Baltimore	ocation of Death		4c. County of	Death
Funeral Director	5. Social Security Number 6. Sex 215-60-5827	7. Age (In yrs. la 2 F 59		If Under 1 Year Months Days	If Under 24Hrs Hours Min	-		9. Birthplace (State or Foreign Country) Maryland
ryland a-f show any tonce.	Usual Residence of Decedent  10a. State 10b. County  Maryland Baltimore	10c. City,	Town or Location	on .				10d. Inside City Limits 1 Yes 2 X No
ith the Maryland 23a or 28a-f sho notified at once	10e. Street and Number 7858 St' Gregory D	rivo		10f. Zip Code 21222		1	0g. Citizen of Wha	,
her death with the ", or items 23a er must be notil	11. Marital Status 12 1 X Never Married 2 Married 1 3 Widowed 4 Divorced If Y	. Was Decedent Ever in U.S Armed Forces? Yes 2 X No es, Give Year	ver in U.S. 13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto				14. Race - White,	American Indian, Black,
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f she crother traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	15. Decedent's Education (Specify only h	Dates:	16a. Decedent	s Usual Occupationst of working life. I	on (Give kind of		16b. Kind of Busi Sagal, C	lassin, Filbert sney P.A.
21215-0036 Juld be filed within 7 Mental Hygiene, marked other than ic event, the Medica FO Be Comple	17. Father's Name (First, Middle, Last)  Carroll		odles		Anna	Angel		Burdelas
e, MD 21 I and 2 should Health and Me item 27 is ma	19a. Informant's Name/Relationship (Type, Michele S. Chojnack	•					Quarters,	State, Zip Code) 21220 Maryland
Baltimore, Nemit. Pages   and Department of Healt Important: If item injury or other trau	20a Method of Disposition  1 X Burial 2 Cremation 3 F  4 Donation 5 Other Specify:	Removal from State	rematory or other	ion (Name of cemer er place) y Cemete	Ма	Date rch 11, 2010		City or Town, State
Baltimo permit. Page Department Important: injury or ot	21. Signature of Funeral Service ticensee	marche	22 Na	me and Address of Dahrows	ki/Choj	nacki Fu	ineral Ho	
Physician /Medical Examiner	23a. Pa/t I. Enter the disease, or complicate failure. List only one cause on each till Immediate Cause (Final disease a. Ath		Do not enter the	mode of dying, s	uch as cardiac c	r respiratory arr	est, shock, or hear	t Approximate Interval Between Onset and Death
Lxammer	Pro Mr. 1 1 M.S.	to (or as a consequence of	):					
ted unsit Examiner	if any, leading to immediate Due cause. Enter Underlying Cause (Disease or injury that initiated	to (or as a consequence of						54
60, e be executed ysician and burial - transit	d	to (or as a consequence of)	): 					
760, icate be execut physician and the burial - tra	IF FEMALE: 2:	MENDED  3c. If yes, outcome of pregn	ancy				23d. Date of d	eliv <b>e</b> ry
). Box 6876( the death certificate by the attending phy tched for use as the b Physician/M	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown g	Live birth Pregnant at time of dea Unknown		of death 3	Ectopic pregna	incy	Month	Day Year
, P.O. E res that the d signed by the be detached d by Phy	Part II. Other significant conditions con	tributing to death but not re	sulting in the un	derlying cause giv	ven in Part I.	23e. Did to		ute to the cause of death?  Probably 4  Unknown
Division of Vital Records, P.O. Box 6876l the Hospital or Attending Physician: The law requires that the death certificate him 24 hours after death.  The Funeral Director: After this certificate has been signed by the attending physphelety filled in by the funeral director. page 2 should be detached for use as the Lical Certification: To Be Completed by Physician/Melical Certification:						1 ✓ Yes	sy pri med? de	ere autopsy findings available or to completion of cause of ath?  Yes 2 No
Vital hysician: hysician: this certif	25. Was case referred to medical examiner?  1  Yes 2 No	tal: 1 Inpatient 2 🗸	ER/Outpatient		of Death (Check other 4 Nursin		Residence 6	Other:
ion of V tending Ph eath. ior: After tl the funeral ation: To	27. Manner of Death  1  Natural 5 Pending	28a. Date of Injury (Month, Day,Year)	28b. Time of Inj		at Work?	28d. Describe	now injury occurred	1
Division o  Division o  Hospital or Attending 24 hours after death. Funeral Director: After filled in by the funeral of Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At hor (Specify)	me, farm, street	, factory, office bui	ilding, etc.	28f. Location (S or Town, S		or Rural Route Number, City
	one) 2 Medical Examiner: On	To the best of my knowledg the basis of examination an manner stated						
To with To coor	29b. Signature and title of certifier	()		29c. License O.C.M		*	29d. Date signed March 7, 20	(Month, Day, Year)
	30 Name and address of person who comp Laron Locke MD. Assistant	Medical Examiner	111 Penn	Street, Baltim	ore, MD 212	<del>-</del> 01		
State Registrar	(3) 11 by 11 by 71 71 11 11	32. Registrar's Signatur	facks	,				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year Physician illiam 0600 M Veazie 2010 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Brook Betresda Montgomen Broad Drive If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1∏ M 2□ F Months Days Hours Yrs 97 May 29, Director 002-30-3135 1912 Hawaii Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or items 23a or 28a-f show dical Examiner must be notified at 1√ Yes 2 No Director MD Bethesda Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4704 Broad Brook Drive 20814 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14 Race - American Indian 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or ite any Injury or other traumatic event, the Medical Examine 11 Yes 2 No If Yes, Give 6-1-33 Year or Date 0 4-30-63 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√☐ No ģ Specify: White 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Manager Banking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harold Boswell Pratt ပ Marguerite Rockwell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12837 Mill Race Court Manassas, VA 20112 Mary Holcomb - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Arlington National Cem 3/25/10 6 ☐ Other (Specify) Arlington, VA 4 □ Donation 21. Signaturu of Fur eral Service License 22. Name and Address of Facilify Pierce Funeral Home 9609 Center St. Manassas, Virginia 20110 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) End **Physician** Demonta /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate outce. Enter the confine Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown signed by t t be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2MNo 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 🔀 No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C 1 🖫 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/2001

#240

Silver Spring

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mary Blanken CENP 11800 Tell Ru

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March ^{Day} 2010 8 3:40 A M Albert Patterson Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 7909 Trappe Road Baltimore Dundalk 8. Date of Birth (Month, Day, July 9 9. Birthplace (State or Foreign Country) Maryland Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Days 1 🔀 M 2 🗆 F Months Hours 220-36-3565 Director 69 940 Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 X No Baltimore Dundalk Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21222 USA 7909 Trappe Road Apt B 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc Completed by 1 ☐ Never Married 2 🔀 Married X Yes 2 ☐ No Yes, Give Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. Specify: White 3 Widowed 4 Divorced Year or Dates 15, Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Baltimore City 12 years Printer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lucille Marie Kaun Bydler Hewitt Patterson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7909 Trappe Road, Dundalk, Maryland wife Jane Patterson Baltimore. 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State March^{Dat} 2, cemetery, crematory or other place) 1 Durial 2 X Cremation 3 Removal from State Bayview Crematory 2010 Baltimore, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or iinjury Due to (or as a consequence of) Exam Hospital or Attending Physician: The law requires that the death certificate be executed and the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Box 68760 use as 1 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) for in the past 12 months? Month Year Pregnant at time of death Yes 2 No the detached g 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? cate has been signed page 2 should be det δ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? performed' certificate 1 🗌 Yes 2 🗌 No completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 - No Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural (Month, Day, Year) work 5 Pending 1 ☐ Yes 2 ☐ No 24 hours after death Investigation 6 Could not be 2 Accident Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in the opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the within 2 To the I only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) No DSS March 8 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Box 68760. P.O. Records, Division of Vital

requires that the death certificate be executed physician and the burial-transil attending properties as use as signed by the a d be detached for has page 2 s certificate After this certification funeral director, I ospital or Attending I hours after death. in 24 hours atter occur.
The Funeral Director: Af Hospital To the within 2.

**Physician** 

/Medical

Examiner

**Funeral** 

Director

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23a

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filed withir Hygiene.

Pages 1 and 2 should be f nent of Health and Mental

permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 Is
any Injury or other trau

**Physician** 

/Medical

Examiner

Examiner

Physician/Medical

2

Completed

Be

Certification: To

Director

Funeral

2

Completed

traumatic event, the Medical Examiner must be notified at

Baltimore, Marylan'd 21215-0036

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Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person DHANJANI 622 SIUNION HAVRE DEGRACE. SURESH 31. Date filed (Month, Day, 32. R Year State Registrar

	1	For State Registrar			artment of H		R	eg. No.	0698		
Physician /Medical	I	Decedent's Name (First, Middle, Las Robert		F	arrish		2. Date of Deat Month March	Day Year 03 2016	3. Time of Death		
Examiner	1	a. Facility Name (If not institution, give	ospital	4b. City, Town, or Location of Baltimore City			8, Date of Birth	4c. County of Death			
Funeral Director	2	5. Social Security Number 6. S 217–84–2639	7. Age (In yrs	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	Aug 17,	Year) 9. Bill Co. 1962 MD	nplace (State or Foreig Intry)		
ied at	1	Oa. State 10b. County PA York	10c. C	City, Town or Lo	cation nover		-		10d. Inside City Limit		
r items 23a or 28a-f sliner must be notified a function of the	1	0e. Street and Number 623 Hobart Road		<u></u>	10f. Zip-Code	7331	1	0g. Citizen of What Coo	g. Citizen of What Country? U.S.A.		
b xam y		1. Marital Status 1 Never Married XXMarried 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces?  1 ☐ Yes 2 ☐ No If Yes, Give XX Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes <b>②【X</b> No	ispanic Origin? (Spe in, Mexican, Puerto I Specity:	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: W	rican Indian, e, etc. nite		
ygiene. her than "natura t, the Medical E Completed	-	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation de completed) College (1-4 or 5+)	(Give	dent's Usual Occup kind of work done o DO NOT use retired SPERSON	during most of worki	ing	16b. Kind of Business/Industry  Auto Parts			
eath and Mental Hygiene. n 27 is marked other than ", er traumatic event, the Med To Be Comple	:   '	7. Father's Name (First, Middle, Last)	Robert Frank	klin Pa	rrish,Sr.	18. Mother's Name	e (First, Middle, un Lulie				
Health and Niem 27 is mai		9a. Informant's Name/Relationship ( Dawn Parrish (Wi	over, PA	Route Number, City or Town, State, Zip Code) Ver, PA 17331							
Department of Hez Important: If item any injury or othe once.	20a. Method of Disposition  1 XX virial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory of other place)  St. Anthony S Church  20c. Location - City or Tow Cemetery, crematory of other place)  St. Anthony S Church  21. Signature of Fundal Service (Geograf)  22. Name and Address of Facility										
Departr Importa any inju		Home Inc.									
ysician ⁄ledical		23a. Part 1. Enter the disease or com- shock, or heart failure. List only mmediate Cause (Final disease or condition esulting in death)	plic of ns that caused the decone cause on each line.  a. SchSiS  Due to (or as a conse		er the mode of dyir	ng, such as cardiac (	or respiratory arr	est,	Approximate Interval Between Onset and Death		
g physician and as the burial-transit		Sequentially list conditions, fany, leading to immediate cause. Enter Underlying Cause (Disease or injury hat initiated events resulting in death) Last	b. Due to (or as a conse				·				
ed by the attending physician detached for use as the buring Y Physician/Medical		F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of preg  1	etal death 3	☐ Ectopic pregnanc☐ Other (specify)	у		23d. Date of del Month	ivery Day Year		
be d	֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓	Part II. Other significant conditions	contributing to death but not i	resulting in the	underlying cause gi	iven in Part I.	23e. Did to	bacco use contribute to es 2 ☑No 3 ☐ Pr	o the cause of death obably 4 \( \subseteq \subseteq \text{Unknown}		
(0 (7)						<del></del>	24a. Was a autops perform	sv prior to	itopsy findings availa completion of cause 2 No		
is certifical I director, p	3 3	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑No	Hospital: 1 Inpatient 2	☐ ER/Outpatier	nt 3 🗆 DOA Oth	26. Place of Deather: 4 ☐ Nursing Hor			cify)		
within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page  Medical Certification: To Be Com		27. Manner of Death  1 Natural 5 Pending 2 Accident investigatio 3 Sulcide 6 Could not be	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	M 1	k̂? Yes 2 □ No	28f. Location (S	ow injury occurred	ural Route Number,		
neurs after neral Direc y filled in b			hysician: To the best of my ki	nowled <i>g</i> e, deat				cause(s) and manner a			
thin 24 hou the Funer ompletely fill		(check only one) 2 Medical Exa  29b. Signature and title of certifier	miner: On the basis of exami and manner stated.	nation and/or if	29c, Licens			gate and place, and du 29d. Date signed (Mont			
M 6 8		) / / / / C		=		S 000		March D3	2010		
		30. Name and address of person who	completed cause of death (I	tem 23a) (Type				Ife St, Baltime			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month March Wayne Arthur Putnam 12010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Lanham Doctors Community Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** Hours (Month, Day, Year) 1 X M 2 D F Days Min. Director 393-26-6444 78 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location Director Prince George's MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20715 United States 3835 Irongate Lane 12. Was Decedent Ever in U.S.
Armed Forces?
1 M Yes 2 □ No
If Yes, Give
Year or Dates 1949-1952 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 5+Software Engineer Aerospace Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Arthur Putnam Martha Laubenstein 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lee W. Putnam / Son 15046 Whittier Loop Woodbridge, Virginia 22193 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arundel Crematory 03-06-2010 Odenton, Maryland 21. Sign Jure of uneral Service Livensee ²². Name and Address of Facility Donaldson Funeral Home & Crematory, P.A. 1411 Annapolis Road Odenton, Maryland 21113 23a Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Respiratory disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner ipuxi c Sequentially list conditions, rany, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Renal that initiated events resulting in death) Last Physician/Medical meta bouic acidosis Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown 5 Other (specify) Pregnant at time of death ed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Syndome Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed Electrolyte Imbalance 24a. Was an cate has I autopsy performed? Yes 2 this certificate **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) æ examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2. No မ Inpatient 2 I ER/Outpatient 3 I DOA within 24 hours after death.

To the Funeral Director: After th completed filled in by the funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

5:45 PM

9. Birthplace (State or Foreign

10d. Inside City Limits

Approximate Interval Between Onset and Death

1 Yes 2 X No

Country)
Wisconsin

Black, White, etc.

Month

Day

24b. Were autopsy findings available prior to completion of cause of death?

1 Tyes

2-2010

2 🗌 No

Year

White

DHMH 17 Rev 7/2009

State Registrar 29a. Certifier

29b. Signature and title of certifier

31. Date filed (Month, Day Year) -

Mems

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8 118 Good

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Lanham

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year Melvin Potocki 3 2010 March 11:45a 4a. Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Futurecare - Irvington Baltimore City N/A5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 1⊠ M 2□ F Davs Yrs 219-30-5788 11-7-1934 Marvland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No N/A Baltimore City 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 802 S. Belnord Avenue 21224 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates: 1 ☐ Yes 2 🛛 No Specify: White Specify 3 ☐ Widowed 4 🛛 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) N/A Elementary/Secondary (0-12) 10 Line Worker Brewery 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Efrem Potocki Stella Zaranski 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph Kostkowski-Nephew 4707 Winksley Court Ellicott City, MD 21043 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 🛭 Cremation 3 ☐ Removal from State Bayview Crematory 3-10-2010 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Kaczorowski Funeral Home, PA 21. Signature of Funeral Service Licensee 1201 Dundalk Avenue Baltimore, MD 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory at est shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Metasta disease or condition resulting in death) Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? STallet 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🐧 Unknown

Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical signed by the a I be detached for Completed been has certificate Be Certification: To

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Examine

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Medical

MD

**Funeral** 

Director

show

r than "natural", or items 23a or 28a-f shor the Medical Examinar must be notified at

Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene.

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than any injury or other traumatic event, the Many injury or other traumatic event, the Many once.

**Physician** 

/Medical

Examiner

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physic within 24 hours after death.

To the Funeral Director: After this ce completely filled in by the funeral direc

+1 State

Registrar

· /	1	
,		24a. Was an autopsy prior to completion of cause of performed? 1 □Yes 2 ☑No 1 □Yes 2 □No
25. Was case referred to medical examiner?	26. F	Place of Death (Check only one)
1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐	XNursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death  1 ☒ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury at Work?  M 1 □ Yes	28d. Describe how injury occurred
3 Suicide 6 Could not 4 Homicide determined		28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier 1 ☐ Certifying F (Check only one) 2 ☐ Medical Exa	Physician: To the best of my knowledge, death occurred at the time, dataminer: On the basis of examination and/or investigation, in my opinion, and manner stated.	te and place, and due to the cause(s) and manner as stated. , death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier 29c License numbe 29d. Date signed (Month, Day, Year) 03/04/20/0

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2120 DR. A. AHMED M'aulau

31. Date filed (Month, Day, Year)

Registrar's Signature

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ MARCH 9:11 JoAnn Parham 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death BALTIMORE SINAL HOSPITAL OF BALTIMORE CITY 5. Social Security Number 8. Date of Birth (Month, Day, Year) 07 28 Funeral 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year _ If Under 24 Hrs. 9. Birthplace (State or Foreign 1 □ M 2 🔀 F Months Days Hours Min. Director 224-72-8655 62 Usual Residence of Decedent ms 23a or 28a-f shov must be notified at 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD NA Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral or items 23a 1504 UpShire Road Apt 2B 21218 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. Completed by 1X Never Married 2 ☐ Married 1 Yes 2 No Specify: 3 Divorced 4 Divorced Black Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12th grade lyr Clinical Secretary Health Care Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important; If item 27 is marked oth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Waverly Robertson <u>Mattie Davis</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Troy Parham-Son 3534 White Chapel Road, Baltimore, Md 21215 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other placel Parham 3/13/10 Prince George, VA 21. Sanature of Funeral Service Licensee 22. Name and Address of Eacility March F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a. Palt 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between UROSEPSIS Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Due to (or as a consequence on).

Hypoxemic Encepholopathy Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury sin4 2000 Metastatic Parotid Gland Cancer Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last ARDS (Acute Respiratory Distress Syndrame Physician/Medical IWK Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 9 Unknown 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Dav Year 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypertension 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Thromboustopenia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b lirector, page 2 sl autopsy SIADH (Syndsom of Inappropriate ADH secretion performed? Yes 2 No 1 Yes 2 XNo 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: Other: မ 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Npatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1. ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours at To the Funeral Di completed filled in Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the Brown Reller, MBBS, MPH RES-000 MARCH, 02, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MBBS BALTIMORE BHARAT RATTAN MPH SINAL HUSPITAL OF 31. Date filed (Month, Day, Year)
NAR 0 9 2010 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

PARHAM

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Date of Death
 Month 3. Time of Death **Physician** <u>Joseph Emmett Queen</u> March 7 2010 3:20 /Medical р 4b. City, Town, or Location of Death Towson 4a. Facility Name (If not institution, give street and number) **Examiner** 4c. County of Death
Baltimore Greater Baltimore Medical Center If Under 1 Year | If Under 24 Hrs. | 8, Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 ☐ F Director 219-05-6624 March 3,1917 Mary land Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f sh other traumatic event, the Medical Eran, Leginust be notified Director Maryland Baltimore 1 ☐ Yes 2 ☑ No Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2525 Pot Spring Road Unit K107 21093 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Dayes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) ed other than " Elementary/Secondary (0-12) College (1-4or 5+) Physician Medicine 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Health and Menta em 27 is marked ပ William G. Oueen Loretta Wholey 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Lillian B. Queen (Spouse) 2525 Pot Spring Road Unit K107 Timonium, Md. 21093 20a. Method of Disposition Pages 1 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages 1 Department of H Important: If ite any injury or ot Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☑ Other (Specify) onation 3 ☐ R 5 Other (Specify) Dulaney Valley Mem. Gdns. 3/11/2010 Timonium Maryland 22. Name and Address of Facility Michae Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Md. 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between atic Cordio was ever Piscose Immediate Cause (Final **Physician** 20105cl disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examine attending physician and for use as the burial-trar Due to (or as a consequence of): P.O. Box 68760 death certificate be Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year □Yes 2□No 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy 1 □Yes 1 ☐ Yes 2 ☐ No or Attending Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To Inpatient 2 ER/Outpatient 3 DOA completely filled in by the funeral Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐Yes 2 ☐ No after death 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital e Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) To the within 2 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print). Ch. - KJSt. #Z01 Grenzey, M. D.

State

Registrar DHMH 17 Rev 1/2001

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State State Registrar	of Marylan		artment of H		nd Mental Hy	giene Reg. No.2	0	06986	
	Physici		1. Decedent's Name (First, Middle, Last)		RAT	THEL		2. Date of Do Month	Day	Year 2010	3. Time of Death	
1	/Medic Examin		4a. Facility Name (If not institution, give street and in The Johns Hopkins Hospital	number)		4b. City, Town, or Baltimore			4c. County			
44	Funeral Director		5. Social Security Number $215-12-1031 \\ \text{Usual Residence of Decedent} \\ 6. \text{ Sex} \\ \text{$1 \square$ M $ 2$ $$$} \\ \text{$X$} \\ \text{$1 \square$} $	7. Age (In yrs. Id 88	ast birthday) Yrs.	If Under 1 Year Months Days		Min. 8. Date of Bi (Month, Di June 2	rth ay, Year) 2,1921	9. Birthp Count <b>Mar</b>	lace (State or Foreign ry) 1 y land	
death with the Maryland	be filed within 72 hours after death with the Maryland that Hygiene. By other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral Director	Md. Balto  10b. County  Md. Balto  10e. Street and Number  7930 Bridge Avenue  11 Marital Status		7, Town or Loc	Roseda 10f. Zip-Code 2123	7	ı? (Specify Yes or No uerto Rican, etc.)	10g. Citizen of V		an Indian,	
Maryland 21215-0036	nin 72 hours after n "natural", or it fedical Examine	Completed by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Ye If Yes, 3 🕱 Widowed 4 ☐ Divorced	s 2 No Give X Dates:	1 ☐ Yes 2 ☒ No Specify:  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)			f working	Specify 16b. Kind of B	/: usiness/Ind	White	
ind 212	0 m 0 m	Be	12 17. Father's Name (First, Middle, Last)		Plair	1 Clothes	18. Mother's	tive s Name <i>(First, Middl</i> lda Tripl			· · · · · · · · · · · · · · · · · · ·	
Maryla	id 2 should be filed v Ith and Mental Hygie 27 is marked other t traumatic event, th	ᄋ	John Spence  19a. Informant's Name/Relationship (Type. Print)  Gilman J. Rathel	Son		ng Address (Street  ) Bridge	and Number	or Rural Route Num				
Baltimore,	permit. Pages 1 and 2 should b Department of Health and Ments Important: If item 27 is marked any injury or other traumatic er		20a. Method of Disposition  1 □ Qurial 2 □ Cremation 3 □ Removal fro 4 □ Donation 5 □ Other (Specify)			sition (Name of natory or other place	e)	Date 9-2010	20c. Location - Parkvil			
Balt	permit. Departr Importa any inj		21. Signature of Funeral Service Licensee  23a. Part 1. Enter the disease, or complications that	at caused the death		. Name and Addre	air Rd	. Nottin	ek Funer gham, Md			
	Physician /Medical Examiner		shock, or heart failure. List only one cause or Immediate Cause (Final disease or condition resulting in death)  a. Pulpulpulpulpulpulpulpulpulpulpulpulpulpu		+	5. 4.0 mode e. dy		•			Interval Between Onset and Death	
1,60,	certificate be executed ding physician and use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  C.  Due to (or as a consequence of):  d.									
O. Box 68	death certific e attending p ed for use as	Physician/Me	in the past 12 months?  1 Ves 220No 4 Pr	outcome of pregna ve birth 2  Fetal egnant at time of de nknown	death 3	Ectopic pregnanc Other (specify)	у	23d. Date of delivery Month Day			,	
J.	ires t signe d be	β	Part II. Other significant conditions contributing to	o death but not res	ulting in the u	inderlying cause gi	ven in Part I.	23e. Did	,		ne cause of death?	
	The law ate has b page 2 s	Completed						1 🗆 Yes	propried? 2 No	Were autoprior to codeath?	psy findings available mpletion of cause of 2 \( \square\$ No	
n or vital	To the Hospital or Attending Physician. The within 24 hours after death.  To the Funeral Director: After this certificate completely filled in by the funeral director, pa	on: To Be	27. Manner of Death 28a. Da	Monpatient 2 ☐ ite of Injury	ER/Outpatient 28b. Time of Injury		er: 4 □ Nursi y at	ng Home 5 Res  28d. Describe			)	
DIVISION	I or Attendir after death, Director: Af d in by the fu	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 28e. Pla	ace of injury - At hor ilding, etc. (Specify,			Yes 2 □ No	28f. Location	28f. Location (Street and Number or Rural Route Number, City or Town, Stete)			
	To the Hospita within 24 hours To the Funeral completely fille	edical				estigation, in my o	pinion, death		e, date and place,	and due to	o the cause(s)	
	vitt on con	Σ	29b. Signature and title of certifier		2020\ (Time	29c. License			29d. Date signed			
	Sta	te	31. Date filed (Month, Pay, Year)  31. Date filed (Month, Pay, Year)  32. Date filed (Month, Pay, Year)	. Registrar's Signati	ure _		6	00 North We	olfe St, Ba	ltimor	e, MD, 21287	
	Registr	ar	MAR 09 2010 Leve	a di	books							

DHMH 17 Rev 1/2001

**Physician** /Medical Examiner Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Division or Vital Records, P.O. Box 68760

**Physician** 

/Medical

Examiner

Directo

Funeral

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Completed

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**Funeral** 

**Director** 

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

detached for filled in by the funeral

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cal IF FEMALE 23b. Was decedent pregnant

27. Manner of Death

1 Natural

2 ☐ Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) Injury М 1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

	one)				
29b.	Signature	and	title	of	certifier

31. Date filed (Month, Day, Year)

ATTENDINZ

29c. License number DOD 56948

PLACE SUIFE

34

29d. Date signed (Month, Day, Year) 2010 2 MARCH

BALTMONE NO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

300 MMM Acronat

5 ☐ Pending investigation

6 ☐ Could not be

32. Registrar's Signature Server B.

DHMH 17 Rev 1/2001

State Registrar

or Attending Physiclan:

the Hospital

within 24 hours after death To the Funeral Director:

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #17 Per FH G901 3/17/2010 JH State of Maryland / Department of Health and Mental Hygiene 05988 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Frances Lockwood Regnier 04, 11:45A. M March 2010 /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Edenwald Retirement Community Baltimore County Towson If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕸 🗗 Months Days Hours 212-05-2971 Yrs. Baltimore, MD. Director 94 June 08, 1915 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f sho Director 1 ☐ Yes 2 No Maryland | Baltimore County Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 800 Southerly Road Funeral 21286 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Armed Forces?
1 ☐ Yes 2 2 No 1 Never Married 2 Married If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify: 2 White 3 Widowed 4 Divorced Specify: Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Ŏ2 Home Maker Own Home 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Philip Moore Lockwood Hannah Honora Goodwin or other traumatic ၉ 19a. Informant's Name/Relationship (Type. Print) (Daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 of Department of Health a Important: If Item 27 is any injury or other trau Dr. Elizabeth R. Beil, Ph.D. 4544 Hemlock Cone Way Ellicott City, MD. 21042 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State March 05, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Evans Funeral Chapel 4 ☐ Donation 5 ☐ Other (Specify) Forest Hill, Maryland 2010 Gair, \$12. Name and Address of Facility
Peaceful AlternativesFureral & Cremation Center, P.A.
2325 York Road Timpium, Maryland 21093 21. Signature of Funeral Service Licensee Jeffrey L. 23a. Par J. En er he dightse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Arrhythmias **Physician** ordiac /Medical Due to (or as a consequence of): Examiner Falle yeart Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): sician and burial-tran Due to (or as a consequence of): Physician/Medical the as IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery for 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy 2 **X**No 1 ☐ Yes 2 ☐ No 1 □Yes director, Be 25. Was case referred to medical examiner? 26, Place of Death (Check only one) 1 ☐ Yes 2 No Other: Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending in 24 hours are:
the Funeral Director: Af 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year) Scher 2154032 2010

State Registrar

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Baltimore, Maryland 21215-0036

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Division of Vital Records,

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CRNP

32. Registrar's Signature

800 Scotherly

Towson, MD

#### State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** ROSALES MARCELO 28 2010 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner SPRING CROSS HOSPITAL SILVER MONTGOMERY If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) f Birth n, Day, Year) 9. Birthplace (State or Foreign Country) 28, 2010 MAIRYLAND 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Min Director NA Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Completed by Funeral Director GAITHERSBURG WD MONTGOMER 10e. Street and Number 10g. Citizen of What Country? ö 20886 PIVOT "natural", or items 23a USA Pages 1 and 2 should be filed within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 □Yes 2 □No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 MYes 2 □ No Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) is marked other than Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. INRAN INFANT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JOSE ROBERTO ROSALES NANCY ROSALES ပ 19a. Informant's Name/Relationship (Type; Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra 217 MOTHER NANCY ROSALES POVIG CAITHERSBURG MD 20886 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 X Other (Specify) in state 21. Signature of Funeral Sovice Licensee Wade 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Mixector Baltimore, MD 21201 Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) PREMATURITY **Physician** EXTREME 20 WKS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 **N**o 1 □ Yes 2 No 1 □ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 🗺 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 🖅 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature 29d. Date signed (Month, Day, Year) nd title of cer 031265 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) H 308 your Metchell ville

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

State Registrar

(mA)

31. Date filed (Month, Day, Year

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no 2016

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Rodich Marh Vaniel MA 000/ 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FUTURE CARE CHERRYWOOD Baltmore Reisterstown 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 10M 20F Months Days Hours Min. 2 (V - ZZ - To 73 Usual Residence of Decedent SU Director 3-31-1929 MD with the Maryland 10a. State 10b. Count 10c. City, Town or Location r then "natural", or Itame 23a or 28a-f show the Medical Examiner rount be notified at 10d. Inside City Limits 1XYes 2 No Directo MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3108 BANCROFT ROAD, #E 21215 Funeral USA death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☑ Yes 2 ☐ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
ant: If item 27 Is marked other then "natural", or Italy or other traumatic event, the Madical Examina 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: þ If Yes, Give Year or Dates: Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 MEAT CUTTER SUPERMARKET 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) RUDICH GERTRUDE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DEBBIE SCHWARTZ/NIECE 12 GOLDEN GRASS COURT, OWINGS MILLS, MD 21117 20a. Method of Disposition 20b. Place of Disposition (Name of Kingson) Eclematory Skeller place) 20c. Location - City or Town, State 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Importent: If any injury or once. 4 □ Donation 5 □ Other (Specify) ANSHE KOLK CEMETERY 3/7/2010 BALTIMORE, MD 21. Signature of Juneral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Finaf disease or condition resulting in death) Athoroscheretis Physician vascular diséase rears /Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine signed by the attending physicien and does detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Records, P.O. Box 68760 Physician/Medical fF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 | Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Minknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2□ No Division of Vital 1 🗌 Yes 2 No 1 ☐ Yes or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ٩ 1 ☐ Yes 2 7 No 1 Inpatient 2 ER/Outpatient 3□ DOA After thi 27. Manner of Death 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred 1 XNatural 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: , completely filled in by the f 2 Accident 6 Could not be determined 3 🗌 Suicide Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) March D37573 6105,4 30. Name and address of person who complet a cause of death (Item 23a) (Type, Print) Baltimare 71/2ell Ave 2835 21209 31. Date filed (Month, Day, Year) istrar's Signature State MAR 09 2010 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March 6, Day 2010 at Jr. 11:15A M Keidor Lewis Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Johns Hopkins Bayview Med.Ctr. Baltimore City Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours West Virginia 278-24-1628 Janth 2²⁴, 1929 81 Director Usual Residence of Decedent shov 10a. State 10c. City, Town or Location items 23a or 28a-f shoner items 23a or 28a-f shoner items for a continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the co 10d. Inside City Limits Director 1 🗆 Yes 2 🔀 No Md. Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 21222 2810 Gray Manor Terr. USA should be filed within 72 hours after death vand Mental Hygiene.
is marked other than "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian the Medical Examiner Armed Forces?

Type Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Steel Worker Beth Steel Be traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Logan Lewis Rader Dolly Mullens permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic to 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gary Rader ( Son) 2810 Gray Manor Terr Dundalk, Maryland 21222 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Baltimore,Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2010 Crematory Signature of Funeral Service Licensee 22. Name and Address of Facilitiaczorowski Funeral Home, PA Avenue Baltimore. Dundalk 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Atherosclerotic Physician/ Cavalo Vascu disease or condition Medical resulting in death) Examiner 51 Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of). resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Year Month Day 4 ☐ Pregnant at time of death 9 ☐ Unknown 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Yunknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2**X** No 1 ☐ Inpatient 2 ER/Outpatient 3 ☐ DOA 1 Yes ပ္ 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural Accident 5 Pending injury 1 ☐ Yes 2 ☐ No Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 🕱 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Continuing Number Practioner: 1. The part of the practical of the cause of the first opinion of the practical of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cau (Check 020676 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ad Bayliew 4940 Eastern Avenue Johnstopkins Isadore

DHMH 17 Rev 7/2009

State Registrar

10-01906 Sean William Stellfox

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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ocan william o		1- For State Registrar	state of Maryland		ficate of D		iu Mentari		teg. No. 2 (	010	0699
Physic Medical Exam		Decedent's Name (First, Mid						Date of Dea     Month			3. Time of Death
Wedical Exam	mer	Sean William  4a. Facility Name (if not institut			145	City Tours	or Location of Dea	Month March 7,	2010 4c. County of	(Da = 1)	0956 hrs
		8516 Hydra Lane	ion, give street and number	,		lottinghar		uı	Baltimor		ty
Funeral Director		5. Social Security Number  205-68-0305	6. Sex 7. Ag	ge (In yrs. last	-	f Under 1 Ye Months Da		in	rth(MM/DD/YYYY 19,1978	9. Birth Foreign Cour	place (State or Pennsy1van ^(fry)
any		Usual Residence of Decedent 10a. State 10b. County	,	10c. City, To	own or Location					1	Od. Inside City Limits
yland -f show	ō		Balto.		Notting	gham					1 Yes 2 No
h the Maryland 3a or 28a-f sho	Director	10e. Street and Number			10	of. Zip Code			Og. Citizen of Wh		y?
5-0036 led within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f she the Medical Examiner must be notified at once		8516 Hydra La	12. Was Decedent	t Ever in U.S.	13. Was De	21236 ecedent of H	ispanic Origin? (	Specify Yes or No	US.		n Indian, Black,
death or item	Funeral	1 Never Married 2 X	Married Armed Forces'	? <b>X</b> No			n, Mexican, Puer		White		,
s after ural",	by	3 Widowed 4 D  15. Decedent's Education (Sp	ivorced If Yes, Give Year or Dates:	malatad) 16		s 2 X N	o specify: ation (Give kind of	Lucal, dono	Specify:		White
5-0036 led within 72 hours a Hygiene. other than "natural the Medical Examin	Completed	Elementary/Secondary (0-12					e. DO NOT use re		16b. Kind of Bu	siness/inc	dustry
-0036 d within giene. ther tha	duc	12	4		Surgi	cal Te			1	pital	1
e fi	Be C	17. Father's Name (First, Middle William Stell							Maiden Surname)		
21215 hould be fill nd Mental H is marked	ToE	19a. Informant's Name/Relation	ship (Type, Print )		19b. Mailing Ad	dress (Stre	et and Number or		nber, City or Town		ip Code)
ore, MD 212 is I and 2 should b of Health and Men If item 27 is mard		Emily A. Ste	11fox S	pouse	8516 Hy	,		ttinghar Date	n, Md. 2		num State
		1 Burial 2 X Crematic		ate crer	matory or other p			1-2010	Balto.	•	own, State
Baltimo permit. Page Department o Important: injury or oth		Bayview 3-11-2010 Balto. Md  21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Hor 9705 Belair Rd. Nottingham, Md. 21230									
		Burn a.1	Mellen			Belai					
Physician Medical		23a. Part I. Enter the disease, of failure. List only one cause	e on each line.					or respiratory arr	est, shock, or hea	rt	Approximate Interval Between Onset and Death
Examiner		Immediate Cause (Final diseas or condition resulting in death)	Due to (or as a cons		TOTH TH	LOXIC	LIOH			-	Deau
	<u>_</u>	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conse	200000000000000000000000000000000000000							
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uted nd ransit		events resulting in death) Last	Due to (or as a conse	equence of);							
Ox 68760, eath certificate be executed attending physician and for use as the burial - transi	Medical	X UNPENDED	AMENDED 23	a,27,2	8a-f pe	r me g	901 3-25	-10 vt			
876( tificate ng phys	n/Me	IF FEMALE: 23b. Was decedent pregnant in	23c. If yes, outcor	ne of pregnan	cy 2 Fetal de	eath 3	Ectopic pregn	ancv	23d. Date of o	delivery Day	/ Year
Sox 6 leath ceri e attendii	sician/	past 12 months?	4 Pregnant at	time of death		(Specify)				,	100-
D. B. t the de by the	Phy	Part II. Other significant condi	9 Unknown	h but not resul	Iting in the under	lying cause	given in Part I.	23e Did to	bacco use contrib	oute to the	cause of death?
ires that signed	d by							1 Yes	2 <b>✓</b> No 3	Probab	ly 4 Unknown
ords w requi	ompleted							24a. Was a autop	sy pr	ior to com	esy findings available inpletion of cause of
tal Rec ician: The la certificate h	Com							perfor 1 Yes		eath? ✓ Yes	2 No
Vital ysician: his certi director	Be	25. Was case referred to medical examiner?  1 ✓ Yes 2 No	Hospital: 1 Inpatie	ent 2 ER	/Outpatient 3	26.Place	Other Nursi		Residence 6	Other S	cene
ing Phy After th	n: To	27. Manner of Death	28a. Date of Inju (Month, Day,Y	iry 281	b. Time of Injury	28c. Inju	ry at Work?		now injury occurre		
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Divis pital or At ours after d teral Direc filled in by	Certification:		lid not be		reside	•	building, etc.	or Town, St	tate)8516 H	vdra	Route Number, City Lane
Division of Vital Records, P.O. Box 68760,  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi		29a. Certifier (Check only 1 Certifying F	hysician: To the best of my	y knowledge, d	death occurred a	t the time, d		due to the cause		as stated.	
To the Hos within 24 h To the Fun completely	Medical	one) 2 Medical Exact 29b Signature and title of certific	aminer: On the basis of exar	mination and/o	or investigation, i			at the time, date a			
	-	290 Signature and fittle of certifi	1 201	Ma	50	29c. Licens O.C.			29d Date signed March 8, 20		∪ay, Year)
of sent	ŀ	30. Name and address of person	who completed cause of d	eath (Item 23a	a)						
		Victor Weedn MD JD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201									
St Regist	ate rar	31 Day RM0'902040	Cere 32 Registra	signa							

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Mary Ann Ralkey 4:00 P M 03 /03 /2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Bethesda Health & Rehab. Center Bethesda Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 ☐ M 2 🛣 F Months Days Hours Min. Oct . IV Year 19<u>35</u> 74 Washington D.C. Director 217-34-0244 Usual Residence of Decedent 28a-f shov or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location Director MD Montgomery Silver Spring 1 Yes 2XXNo 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 901 Arcola Ave. 20902 United States within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3 Widowed 4 X Divorced Completed Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o Roger Fairfax Rowley Lydia Gertrude 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George E. Krouse / Attorney 2416 Blueridge Ave., #100, Wheaton, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State Chesapeake Crematory 3/5/2010 injury 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, MD 21. Signature of Funeral Service Liberse 22. Name and Address of Facility
Rapp Funeral and Cremation Services
933 Gist Ave., Silver Spring, MD M00382 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician, disease or condition resulting in death) Pneumonia days Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine cause. Enter Underlying Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the Innertal director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4 Pregnant 9 Unknown Pregnant at time of death 5 Other (specify) Month Day Year Yes 2X No After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Urinary Tract Infection 1 Yes 2 No 3 Probably 4 Unknown Dementia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed?

1 Yes 2XX No Cerebrovascular Accident Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: ၉ 1 🗌 Yes 2**X** No 4 Mursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1XXNatural (Month, Day, Year) 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital within 24 hours a To the Funeral D Medical 29a. Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D43121 wowa March 4, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nurul Chowdhury M.D., 15216 Dino Dr., Burtonsville, MD 20866

State

Registrar

31. Date filed (Month, Day, Year)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #31 State What And Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Month 2010 Bruce Revnolds March Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death 210 Potomac Ct. Sykesville Carroll If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number . Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1XX M 2 □ F 10/3/1924 Pennsylvania Director 219-16-3574 85 Usual Residence of Decedent show if Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f shoother traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location Director 1 😾 Yes 2 🗆 No Maryland Harford Aberdeen 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 221 Schmechel Street 21001 USA 12. Was Decedent Ever in U.S Armed Forces? 104 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, orces? 1943-ve 1946 Black, White, etc. Completed by 1 Never Married 2 Married 1X Yes If Yes, Give Maryland 21215-0036 1 Yes 2X No Specify: white 3 ☑ Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) civil service US Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Herman B. Reynolds Esther E. Purdy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 Larry Reynolds (son) 210 Potomac Ct., Sykesville, MD 21784 permit. Page 1 and 3 Department of Healt Important: If item 2 any injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Harford Memorial Gardens 3/8/2010 Aberdeen, Maryland 22. Name and Address of Facility
Tarring-Cargo Funeral Home, P.A.
Aberdeen, Maryland 21001 Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that cause . Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to minediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Ectopic pregnancy Month Year 4 Pregnant 9 Unknown Pregnant at time of death 5 Other (specify) Dav 1 Yes 2 L been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? Yes 2 No 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one examiner? Hospital son's 2 1 No 2 1 Inpatient 2 ER/Outpatient 3 DOA After this Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural work? 5 Pending 2 Accident
3 Suicide Investigation within 24 hours after deat To the Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nyrse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only of 29c. License number 29d. Date signed (Month, Day, Year) 35 Center 555 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) orminater, mi 31. Date filed (Month, Day, Year, State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ March 6. THOMAS DONALD REISERT 2010 11:55A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign 1 X X M 2 □ F Days Hours Min. Rhode Island Director 039-05-0140 88 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County 10c. City, Town or Location 72 hours after death with the Maryland 10d. Inside City Limits Director Maryland Prince George 1 Tes 2XXNo Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3142 Gracefield Road #MG321 20904 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XX "natural", or item edical Examiner m 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2XX Married Š 1 Yes If Yes, Give Maryland 21215-0036 1 ☐ Yes 2XX No Specify: Specify: White 3 Widowed 4 Divorced Completed and Mental Hygiene.

is marked other than "natural umatic event, the Medical E. Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business Industry (Specify only highest grade completed) Flementary/Seconday (0-12) College (1-4 or 5+) Engineer Aerospace Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F John William Reisert Catherine Theresa Neilan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any in]ury or other trau Jean A Gloff Dtr 3718 John Carroll Drive Olney, Maryland 20832 Baltimore, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State Dulaney Valley MEm Grons Mar 9,2010 Timonium, Maryland ☐ Donation 5 ☐ Qther (Specify) ignature of Fun 22. Name and Address of Facilian 0 Mitchell IV Funeral Services of Dulaney Valley 200 East <u>Padonia Road Timonium Maryla</u>nd 21093 cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, e cause on each line. Part 1. Enter the disease, or compshock, or heart failure. List only Approximate Interval Betweer Immediate Cause (Final Days Piliysiciail/ Myocardial Infarction disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Coronary Artery Disease Years Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence on that the death certificate be executed and the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last the attending physician hed for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IE EEMALE nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 

Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Day Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by or Attending Physician: The law requires Gastrointestianl Bleed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? this certificate 1 Ves 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 **X X**No Inpatient 2 DER/Outpatient 3 DOA Certificate: To 4 Nursing Home 5 Residence 6 Other (Specify) To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director; After this completed filled in by the funeral dir Manner of Death Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 5  $\square$  Pending Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 1 XX certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Jurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

15

Registrar
DHMH 17 Rev 7/2009

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

MAR 09 2010

D24035

Eugenio Maimado 3110 Gracefield Drive Silver Spring Maryland 20904

March 7, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ Month Year George W. Stallings 08:25 PM March 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Mandrin Hospice House Harwood Anne Arundel **Funeral** Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, 1 X M 2 □ F Months Days Hours Min. Director 212-28-6867 77 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at should be filed within 72 hours after death with the Maryland and Mental Hygiene. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Anne Srundel Millersville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 773 South Mesa Road 21108 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2 No Black, White, etc. 1 ☐ Never Married 2 ☑ Married þ Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: If Yes Give White Specify: 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Supervisor US Postal Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Unknown Stallings Elizabeth Parks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Jean M. Stallings (spouse) 773 South Mesa Road, Millersville, MD 21108 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 KI Cremation 3 Removal from State cemetery, crematory or other place) March 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 20Ï0 Baltimore, Maryland 21. Signature of Firm ral Se 22. Name and Address of Facility Stallings Funeral Home, 3111 Mountain Road, Pasadena, MD 23a. Part 1. Enter the disease, or shock, or heart failure. List of ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest bause on each line. Interval Between Immediate Cause (Final Qnset and Death Sma Physician, month disease or condition Medical resulting in death) Due to (or as a consequence of). Examiner Sequentially list conditions, Due to (or as a consequence of) if any leading to immedicause. Enter Underlying Examin Cause (Disease or linjury that initiated events resulting in death) Last -tran Due to (or as a consequence of): attending physician for use as the burial Physician/Medical or Attending Physician: The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Day Pregnant at time of death signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 📈 Unknown been si should b 24b. Were autopsy findings available 24a. Was an s certificate has b lirector, page 2 sl autops, performed //ss_2 / No prior to completion of cause of death? 1 ☐ Yes 2 💢 No 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) Hospice House 1 Tyes 2 No Other: ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 27 Manner of Death 28a. Date of injury (Month, Day, Year, 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined To the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie

State Registrar

311

P.O. Box 68760

Division of Vital Records,

who completed cause of death (Item 23a) (Type, Print)

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# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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			Registrar			Cer	tificate of L	Death		F	eg. No. 2	010	06997
	Physicia	ın/	1. Decedent's Name (First, Middle, Last,							Date of Dear     Month	h Dav	Year	3. Time of Death
	Medic		James Robert Sh	erman						March	5 Day 20	010	10:10p ^M
	Examin	er	528 Klee Mill Roa				4b. City, Town, or					inty of Death	
	Funeral		5. Social Security Number 6. Sex		ge (In yrs. las	t birthdav)	If Under 1 Year	esvil		8. Date of Birth		arroll	place (State or Foreign
	Director		215-30-9620	M 2 □ F	74	Yrs.	Months Days	Hours	Min.	May II,	1935	Kent	try) Cucky
	, ow		Usual Residence of Decedent									110110	detty
	ryland -f sh	ctol	10a. State 10b. County		10c. City,	Town or Loc						1	I 0d. Inside City Limits
	e Ma r 28a notif	Director	Maryland Carro  10e. Street and Number	<u> 11                                  </u>		Syke	sville	. <u> </u>					1 🗌 Yes 2 🔀 No
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	ath w	Funeral	528 Klee Mill Roa	U 12. Was Decedent	Ever in I.I.S.	13 W	/as Decedent of H	784	in2 (Spec			State	
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21215-0036	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed)	1	16a. Deced	ent's Usual Occup	ation Jurina most	of workir	ng I	16b. Kind o	f Business Inc	dustry
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Maryland	ould be filed within 72 hours after death with the Maryland id Mental Hygiene. marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at	일	Milfred Sherman						roth	(First, Middle, N	aiden Suma B <b>r</b> c		
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	d 2 stanth and the alth and 127 is		Barbara Sherman/ W	li fe	-		ee Mill						
e,	1 and of Heal f item		20a. Method of Disposition		20b. Pla	ce of Dispos	ition (Name of		rch ^D			on - City or To	
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alt	permit. Departr Importa any inju		21. Signature of Funeral Service License	Amanda :		n 22.	Name and Addres	s of Facility					yland, Inc.
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	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending prompleted filled in by the funeral director, page 2 should be detached for use as	Medical	(Check 2 Medical Examine only one) 3 Certifying Nurse	r: On the basis of e	examination ar	nd/or investig	ation, in my opinior	<ol> <li>death occ</li> </ol>	urred at t	he time date and	place and o	due to the cou	ea(e) and manner stated
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	12		30. Name and address of person who cor	npleted cause of o	eath (Item 23	Ba) (Type, Pri	nt)		_	01 -	/ "/	1	
	10		MILHABL PURTEU	JARAN.	c 49	140 /	ATTERY	AV	- 1	MUTIMO	Le N	nd 21	224
	State Registra		31. Date filed (Month, Day, Year)  MAR 0 9 201		ar's Signatur	La	and a				,		
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#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Day Year PM 15 Lillian Evelyn MIARC Sands /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ma imure HOSPITAL N/A| Trunder 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 05/27/1917 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1 □ M 2 🕱 F Director 92 Maryland 220-14-7808 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City. Town or Location r than "natural", or items 23a or 28a-f show 10d. Inside City Limits Director Yes 2 No N/A Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral S. Culver Street 21229 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: þ Specify: 3 ₩ Widowed 4 □ Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important; If item 27 is marked other than 'any Injury or other traumatic event, Ite Magnes. Elementary/Secondary (0-12) College (1-4or 5+) 12th Grade Warehouse Inspector Department Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lee Α. Wallace Mary Ε. WHite ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tony Sands (Son) 47 S. Culver Street, Baltimore, MD 21229 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 03/17/10 Garrison FOrest Baltimore, MD 21. Signature of Funeral Service Licenses Joseph H. Brown Jr. Funeral Home 2140 N. Fulton Ave., Baltimore, MD illiamo 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PHELMONIA **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease of injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the burial-tran Due to (or as a consequence of): attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🕱 No Month Year Day 5 ☐ Other (specify) 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy perform 2 **N**0 1 □Yes 2 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 🕱 No 1 MInpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 □ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide 29a. Certifier

(1/1)(1/2) = (1/1/4/1)Sivision of Vital Records, P.O. Box 68760, within 24 hours after deatl To the Funeral Director: Hospital or

Baltimore, Maryland 21215-0036

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number

29d, Date signed (Month, Day, Year)

Vall MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2010 5

31. Date filed (Month, Day, Year)

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MD 32. Registrar's S

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State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend state of Maryland Department of Health and Mental Hygiene

		•	1 - State Registrar		,	Certificate of	Death	,	Reg. No.	0 0000	
	D!		1. Decedent's Name (First, Middle,	Last)				2. Date of De Month	ath Year	3. Time of Death	
	Physicia Medic		Lunette Simmons					March	1 2010	4:00 P. M	
	Examin	ıer	4a. Facility Name (if not institution,			4b. City, Town, o	or Location of De	eath	4c. County of De		
			12804 Woodnore Nort  5. Social Security Number		(In yrs. last birth	Bowie		rs. 8. Date of Bir	Prince G	COLPES Birthplace (State or Foreign	
	Funeral Director		206-18-5918	6. Sex 7. Age 1 ☐ M 2 🗓 F		Yrs. Months Days		in. 140nth, 20	y, ver019	Country) VA	
	ov at	_	Usual Residence of Decedent  10a, State 10b, County		10c. City, Town	or Location				10d. Inside City Limits	
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	with the s 23a or ust be n	Funeral Director	10e. Street and Number 7505 7505 Remoon Road			10f. Zip Code	L207	10g. Citizen of What 0	g. Citizen of What Country?  USA		
900	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	至	11. Marital Status 1 ☐ Never Mamed 2 ☐ Marr 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ev Armed Forces? 1  Yes 2  N If Yes, Give Year or Dates.		13. Was Decedent of If Yes, specify Cub  1 ☐ Yes 2 🏋 No	an, Mexican, Pu	(Specify Yes or No- lerto Rican, etc.)	Black, Wh	nerican Indian, hite, etc. ican-American	
21215-0036	n 72 hou an "natu Medica	Completed	15. Deceden (Specify only higher Elementary/Seconday (0-12)	s Education grade completed)  College (1-4 or 5+)		Decedent's Usual Occu (Give kind of work done life. DO NOT use retired	during most of v	working	16b. Kind of Busines	ss Industry	
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lan	i be fil fental rked tic ev	မ	Roper Williams				Julia	Fizgerald			
Maryland	12 should lith and N 27 is ma r trauma		19a. Informant's Name/Relationsh Nellie Williams/ De			Mailing Address (Street 2804 Woodnore			-	Zip Code)	
Baltimore,	age 1 and ent of Hea nt: If item y or othe		20a. Method of Disposition  1	3 Removal from State	20b. Place of cemeter	Disposition (Name of y, crematory or other pla	ce)	Date	20c. Location - City		
Baltir	permit. P Departme Importar any injur		21. Signature of Funeral Service L		/ *		ess of Facility W		l Home PAof		
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Box 68	Hospital or Attending Physician: The law requires that the death certificate be executed 42 hours after death. 43 hours after death. Funeral Director: After this certificate has been signed by the attending physician and tend filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of Live Birth 2 4 Pregnant at 9 Unknown	! ☐ Fetal death	3 Ectopic pregnar 5 Other (specify)	су		23d. Date of o Month	delivery Day Year	
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0			Sm. Cel	ler, MEDI	CAL DOC	TOR RE	5-001		MARCH 3	3,2010	
			30. Name and address of person v							1231	
	Sta Registra		31. Date filed (Month Day Year)	2010 32 tegistrar	's Signature	ball	<u>. C 1 +5/</u>	111101		- 0,	
				7.7			<u> </u>				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Feldruary 28, Day 2010 Year Mary Lee Sessons 12:55 A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death  $\mathbf{r}$ Takoma Washington Adventist Hospital 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. North Carolina 1 🗆 M 2 🔽 F 14746/1926 Director 226-40-9795 83 Yrs Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medi-al Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director D.C. Washington 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20024 USA 1200 Delaware Avenue, S.W. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Black Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7; Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Private 11th Housekeeper Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ George Randolph Mary Sutton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 317 Wimbledon Chase; Chesapeake, Virginia 23320 Ruth Allmond - Sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Durial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 03/07/2010 | Beltsville, MD Chesapeake Crem. 22. Name and Address of Facility Freeman Funeral Services 4594 Beech Road; Temple Hills, MD Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. 23a, Part Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Medical Examiner Gequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury sician and burial-transit Exami The law requires that the death certificate be executed that initiated events resulting in death) Last attending physician Physician/Medical Box 68760 as the t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death nse 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) b in the past 12 months?

1 Yes 2 No Month Year Pregnant at time of death ed by the a 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed to should be deta 23e. Did tobacco use contribute to the cause of death? ģ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2 No Sacral 25. Was case erred to medical examiner?

1 Yes 2 No Division of Vital within 24 hours after death.

To the Funeral Director; After this certific completed filled in by the funeral director, or Attending Physician: Be 26. Place of Death (Check only one) 2 Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 29b. Signature ag 29d, Date signed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar 4701 Randolph Rd # 216.

ROCKINGE MD ZO852

of person who completed cause of death (Item 23a) (Type, Print)